

PUBLIC HEALTH NURSING

Official Organ of the National Organization for Public Health Nursing, Inc.

SETTING THE PACE

SETTING A PACE implies that there is a goal, some experience or ability in reaching that objective, and usually, a desire to improve the method of reaching the goal or quickening the pace.

Our goal is a better health service for all the people. There are hazards or handicaps on the course, in the form of new problems, newly recognized needs, lack of adequately prepared nursing staff, and lack of general knowledge of the value of certain activities or types of work. More than 23,000 public health nurses are struggling to reach this goal with the help of other professional workers and citizens' groups who are interested in and informed about a public health service and the role of the public health nurse. They know the course. They are seeking help to overcome the handicaps along the way.

The National Organization for Public Health Nursing is the means by which individuals can pool their experience and profit by each other's success. The Organization provides a staff to study public health nursing problems, to gather information concerning the practice of public health nursing in various fields, and to report these findings to nurses and others who are interested. Upon the basis of this broader knowledge, the staff also gives to individuals and nursing organizations direct help with spe-

cific problems. The Organization and its members are always striving to improve the methods of work, to meet new problems effectively, and to recruit and prepare enough nurses to meet the demand.

Moreover, the various committees—which are made up of members—and the Board of Directors—which is elected by members—decide upon the policies which guide the staff in making recommendations. The N.O.P.H.N. is truly a membership organization, designed to meet the needs of its members and to promote those practices which make it possible for public health nurses to contribute most efficiently toward the goal—better health for all.

In 1939, we had the largest membership ever enrolled—10,300. Great credit is due the state and local membership representatives, who have given generously of their time and interest in bringing the values of N.O.P.H.N. membership to the attention of public health nurses and others interested in promoting health services.

The Organization needs its members, and its members need it. Let us set a new pace in membership and in service—at least 12,000 members for 1940. A new year, a new pace!

AMELIA GRANT, R.N., *Chairman
National Membership Committee*

CUR 1940 GOAL—12,000

THE NURSE IN DIABETES CONTROL

DIABETES is a problem about which public health nurses know all too little, especially those of us who have not been in recent contact with hospitals and medical clinics. Yet in 1937 it was the ninth cause of death in the United States. "Diabetes is increasing," Dr. Elliott P. Joslin tells us in his article on this subject, "because people cease to die young and live to die old." (Page 3.) Like other so-called chronic diseases of middle life it therefore is assuming increasing importance as a health problem.

An intelligent attack on any disease presupposes an understanding of its cause, the predisposing factors, the incidence and usual age of onset, the symptoms, what measures will help to prevent or retard its development, possible complications, and of course the methods of treatment. Dr. Joslin summarizes succinctly our present knowledge regarding the cause of diabetes and the factors that contribute to its onset. In spite of the fact that it is a hereditary disease he paints a hopeful picture of the increase in life expectancy of diabetics and the possibility of preventing or retarding the onset of the disease. Particularly intriguing are the glimpses of recent research on the influence of the pituitary gland, which may lead to new possibilities for control through endocrine therapy.

What is the place of the nurse in this picture? The public health nurse is in intimate touch with the homes of the community. As part of her day-by-day work she is listening to problems and worries of patients and parents. Significant facts in family history are told her while she bathes the aged grandmother or gives a treatment to Aunt Mary. It is frequently she who learns that there is diabetes in the family; she who discovers the predisposed patients

who should be aware of the hazard and know how to safeguard themselves against it. In order to assist in the prevention of diabetes the nurse must first of all know what people are predisposed to it.

Early discovery and treatment of the disease are vitally important. Again it is the nurse who is frequently the first person to be told about symptoms; who refers the patient for early medical care so that the proper treatment may be instituted in time to interrupt the progress of the disease.

Finally, the nurse may help to reinforce the doctor's directions, to interpret the treatment to the patient, and to help him carry it out properly and regularly with the resources at his command. Particularly in rural areas which do not have diabetic clinics with nutritionists to supervise the teaching of patients, the nurse has a very real responsibility for their education. Frequently it is she who, at the doctor's order, teaches the patient or a member of the family how to administer insulin accurately and with a safe technique.

The nurse can play a part in the prevention of dangerous complications in diabetics, such as diabetic coma—especially in children—and preventable gangrene and infections. Here again she reinforces the doctor's teaching and helps the patient and family to apply it. She emphasizes the absolute necessity for prompt medical attention at the first warning symptoms of coma. She demonstrates the proper hygienic care of the skin and nails and the care of slight injuries which might have serious results.

The present series of articles is presented through the generosity of the George F. Baker Clinic in Boston to bring our readers up to date on diabetes and to stimulate further study on the control of this disease.

Diabetes—A Public Health Problem

By ELLIOTT P. JOSLIN, M.D.

The significance of diabetes as a health problem, its incidence in the United States, and causative factors are discussed by the leading authority on the subject

IN 1938 diabetes ranked eighth as a cause of death in New York City and it was sixth as a cause of death in females. In the entire United States in 1934 it was ninth, but in 1900 only twenty-seventh. Diabetes, therefore, is a public health problem and increasingly so. How many diabetics there are now living in the United States no one knows, but the lowest estimate is 500,000 and I think 600,000 and even more will come more nearly to the truth.

Why is diabetes increasing and why are there so many diabetics? Diabetes is increasing because people cease to die young and live to die old. Two thirds of the cases of diabetes begin after 40 years of age. In 1900 the average age of people living in the United States was 26.3 years; in 1937 it was 30.8 years. The average age at death in 1900 was 35.2 years; in 1937 it was 53.4 years. Since diabetes is most likely to develop between the ages of 45 and 55 years, we must wait some years before we have reached the age at which it begins to decline.

Diabetes is discovered more frequently today because of better medical care and better facilities for diagnosis. It speaks well for the United States that we have the highest diabetic incidence of any country in the world, and most of us believe the reason for this is that our people have the best medical care of any country in the world. If we continue to expand our present methods of medical care, undoubtedly we will find

more diabetics and find them at an earlier stage of their disease, just as we are finding cases of tuberculosis and cancer at earlier stages of their course.

LIFE EXPECTANCY OF DIABETICS

Diabetics are more numerous because they are living instead of dying. Up to 1914 my diabetic children hardly averaged a year of life, and by 1922, the year of the discovery of insulin, their duration of life was only a scant two years. But today there are 151 of them who already have lived over 15 years since their diabetes began. Several years ago, the Metropolitan Life Insurance Company calculated that the expectancy of life of one of these diabetic children at the age of 10 years was 31.7 years,* and today I am sure the expectancy is still greater. Likewise with adults the duration of the disease has increased. Indeed it has more than doubled, and I believe that individuals who develop diabetes in 1940 certainly will have an average duration of 20 years of life even though we include in the group those with onset at 80 or more years of age. Diabetics are living, not dying, and each year we can expect to see more of them. Soon we will be dealing not with 600,000, but with 1,000,000.

The cause of a disease is always a public health problem. What is the cause of diabetes? All agree that it is a

* Joslin, E. P., Dublin, L. I., and Marks, H. H. "Studies in Diabetes Mellitus; Mortality and Longevity of Diabetics." *American Journal of Medical Science*, May 1938, p. 596.

hereditary disease. Granted it is hereditary, what are we going to do about it? Before answering that question, consider a few principles which underlie its transmission. Although it is hereditary, the heredity must be present on both sides. In other words it takes two to make a diabetic. Granted the worst possible heredity, both parents being diabetic, theoretically all their children should have the disease; but by no means should one infer all will live to develop it. Diabetes is rare in the early decades; it becomes more frequent in the middle decades, less common in the later decades. There is a definite ratio of onset per decade. As a matter of fact, it has been shown that if there were 100 children born of diabetic parents, only 44 of them would live to that decade of life in which they were to come down with the disease. But this is not all. Of these 44 to-be-diabetics, only 14, or one third, would develop it under the age of 40; another 14 would develop it between 40 and 55 years of age; and the remaining 14 would not acquire it until between 55 and 100 years of age. Therefore, even at the worst the hereditary factor is not as dreadful as one might surmise.

If one parent has the disease and the other parent is free from it, but simply has a hereditary tendency because of a relative, then the percentage of their children coming down with the disease will be one-half as great. If neither parent has the disease, but it was present in the ancestors of both, the proportion developing diabetes will become still less.

Shall one sterilize all the diabetics in the country in order to stop the transmission of the disease? That would be quite an undertaking in itself. But remember that even if one succeeded, the disease would not be eradicated unless one also sterilized all the brothers and sisters of diabetics, to say nothing of other relatives, and that would not be a popular procedure. The disease is

widespread. It has been estimated that one in four of the people of this country has a tendency to it, and I leave it to you, public health nurses, is not this enough of a public health problem to demand your attention?

OBESITY A PREDISPOSING CAUSE

The chief inciting cause of diabetes in the hereditarily predisposed is obesity. I investigated 1000 diabetics. There were 252 of the number who came down with the disease between 50 and 60 years of age, and of these only one percent was underweight. In the first three decades of life, obesity is not a prominent precursor, but for most diabetics it is the outstanding causative factor. However, it is not every fat man or woman who is liable to develop diabetes, but only the hereditarily predisposed.

Recognizing the importance of obesity preceding the onset of diabetes, the necessity to prevent it among all the relatives of diabetics is obvious. Even with young people having the disease in their family, one would guard against obesity, although not with as good a chance of warding off the disease by this means as with older persons. During the middle and later decades of life it should be an absolute rule for relatives of diabetics to keep their weight within normal limits, or better still a little under normal. It is a good thing to avoid obesity anyway, because in middle life and later, those who are 10 percent and even more under average weight live the longest. Since two thirds of the cases of diabetes develop after the age of 40, there is a good chance of success in preventing or deferring its onset, even in the hereditarily predisposed, by not being fat.

Diabetes is a disease of the islands of Langerhans of the pancreas. These little groups of cells altogether do not weigh as much as a buffalo nickel. One can even destroy up to nearly nine tenths of these and diabetes will not

develop, but go beyond that and the disease appears. It is true that in only about 74 percent of pancreases examined at autopsy can one demonstrate disease of the islands. For the balance one must assume that the function of their cells is deficient.

INFLUENCE OF PITUITARY GLAND

For years it has been known that the other endocrine glands—the thyroid, the pituitary, the adrenals, and also the liver—had close associations with diabetes. But it is only in the last decade that attention has concentrated on the pituitary. Harvey Cushing noted that diabetes was not infrequent in his acromegalic patients.¹ Houssay in the Argentine demonstrated that if one took out the pituitary gland from a dog, made diabetic by removal of his pancreas, the disease became milder.² Still more recently Evans in California noted the appearance of sugar in the urine even lasting a few months when an extract of the anterior pituitary gland was injected into a dog.³ But the culminating proof of the influence of the pituitary was found by Dr. F. L. Young in London who by daily injections of an extract of the anterior pituitary gland into a dog during three to four weeks produced permanent diabetes. The type of diabetes brought about by Young was not so different after all from that caused by removal of the pancreas, because when the pancreases of Young's dogs, made diabetic by pituitary extract, were examined it was seen that the islands

of Langerhans were diseased.⁴

This new work of Young represents the greatest advance in diabetes since the discovery of insulin. It has a suggestive and hopeful feature. The dogs were made diabetic only by repeated injections. After each of the preliminary injections sugar would disappear from the urine only to reappear with a subsequent injection, larger in quantity than the first. Studies of these animals indicate that along with the hormone of the pituitary which was responsible for the diabetes, something else was acting to combat the effect of the pituitary. What that is no one knows, but if this anti-diabetic principle could be found, then who can tell but what one might vaccinate the relatives of diabetics and thus prevent their acquiring the disease—and even learn of a new method of treating the disease in those who have it.

Diabetes is as much a private home problem as it is a public health problem. It is a disease which lasts for life. It concerns each member of the family and their descendants as well. It influences the composition of each meal. It dictates the going out and coming in of the one who has it. And yet if nurses and doctors will only study the disease and tell the patients what they know, it is a fact that he who has it can live almost the life of those about him.

This is the first of a series of articles on diabetes by the physicians of the George F. Baker Clinic, Boston, Massachusetts. The next article will appear in an early issue.

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³ Evans, H. M., Meyer, K., Simpson, M. E., and Reichert, F. L. "Disturbance of Carbo-

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⁴ Young, Frank G. "The Anterior Pituitary Gland and Diabetes Mellitus." *The New England Journal of Medicine*, October 26, 1939, p. 635.

Functional Scoliosis

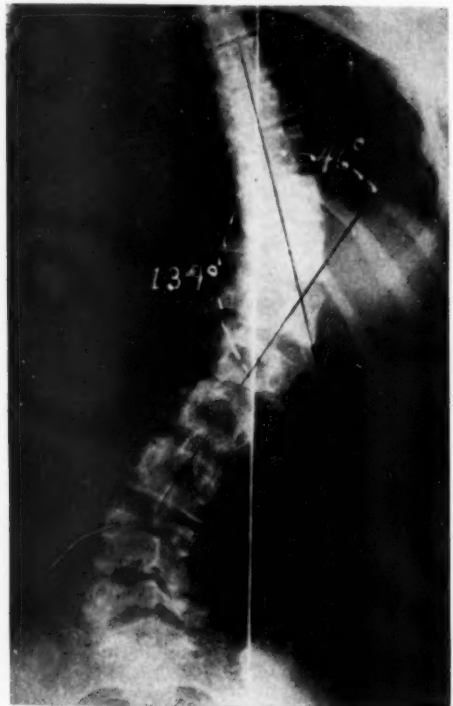
By P. M. GIRARD, M.D.

What is the cause of functional scoliosis? Can it be prevented? How is it treated? This problem is of special interest to all nurses who work with children

SCOLIOSIS is a lateral curvature of the spine usually associated with rotation. Functional scoliosis is such a curve which the child is able to correct voluntarily. There have occurred no permanent changes in the bones or soft tissues, and the extent of the deformity is invariably within the range of normal spinal movement. This condition assumes significance only if it be permitted to exist sufficiently long to

produce structural changes with subsequent uncorrectible deformity.

The spine consists of a series of superimposed joints in which the individual movements are small, but in which the total motion is considerable. Like all other joints, or systems of joints, the maintenance of stability, strength, and form is dependent not only on the bony connections and fittings but mostly on the elements which provide joint mo-



Postural scoliosis—no bony changes have occurred as yet



Structural scoliosis

Note wedging of vertebrae in midthoracic region; also external rotation of bodies of vertebrae in lumbar region

tion—namely, the muscles. The upright carriage of humans is only possible through the supporting action of muscles. A detailed study of the spinal musculature is necessary before one is able to treat, or to even understand the cause of, abnormal curvatures of the spine.

The exact causes of functional scoliosis have never been determined. It is, however, practically always associated with weak musculature and with habitual faulty posture or attitudes. It is often found with other evidences of muscle weakness such as round shoulders, protruding abdomen, and relaxed, painful feet. It should be looked for in patients whose musculature has deteriorated severely through prolonged illness or recumbency. A slight difference in leg length may lead to spinal curvature, and cases have been reported in which a curve resulted from disabilities in one

arm, from wry neck, and from imbalance in hearing or vision.

Functional scoliosis occurs in about five percent of the population, nearly all the cases being found in children. The rapid growth of a child, with a consequent rapid fatigue, makes him particularly vulnerable to such deformity. Prescoliotic indications may be seen in school children who have inclinations to assume asymmetric attitudes in walking, standing, or sitting. These might be termed postural slouches. At school age, spinal curvature is more commonly found in boys than in girls, but at adolescence it is more often present in girls. This may be due to the fact that boys more rapidly develop the muscles which correct the deformity or that the girls are more conscious of physical defects at this age period.

The deformity is not accompanied by

pain or any other symptoms which the patient may notice. Most of the cases are found accidentally by parents, by dressmakers, or by the patient himself when he sees his image in a long mirror. The curve—as outlined by the examining physician who marks the tips of the vertebræ with a skin pencil—is C-type with the convexity to the left, in over 90 percent of cases. Thus the right shoulder is somewhat depressed. Many investigators believe that the curve is away from the left because of the pressure of the great blood vessels passing from the left side of the heart to form an arch; there exists, therefore, a solid column of blood under great pressure left of the midline of the body. Others have pointed out that the curve is produced in school children by their sitting and writing in one-armed chairs. Also, carrying books to and from school would aid in producing the same curve. The books are usually carried in the right hand, most of their weight being placed on the right hip.

Treatment may be divided into the

general and specific forms. The resiliency and flexibility of the muscles and ligaments of children make such treatment fairly effective. If the child is anemic and without the normal physical energy for his age-group he should be given general exercises not only for the spinal muscles but for the muscles of the extremities also. This routine would include postural work, and a build-up of physical reserve by vitamins, sunlight, and adequate diet. He should also have some mental stimulation in order to counteract the usual listless demeanor noted in these children. Any mild form of exercise is beneficial. The most helpful are swimming and light outdoor games in which the child must compete with others. The immediate aims are to promote muscle tone and to interest him in the project. In most cases this form of treatment is effective if the child is coöperative. It is wise indeed for parents to encourage their children in physical development as a preventive against faulty posture which may result in a definite spinal curvature.



Shifting exercise



Crawling exercise

Position of arms and legs depends on whether curve is to right or left

Specific treatment is necessary if the scoliosis has been present for a long period of time or if the child shows no improvement following general treatment. The writer favors starting at once with definite corrective exercises in all cases, in addition to increasing the tone of the general musculature. There may be a definite group of weakened muscles which have allowed the stronger ones of the opposite side to become shorter. Thus, the shortened muscles must be stretched while the weakened group is made stronger. As shown in the illustrations, various exercises have been devised which develop one specific group. This direct treatment, as noted above, is combined with general postural work, deep breathing, and mild competitive playground activities.

If it be found that the patient's muscles are not able at first to maintain the corrected position, then a light back brace, abdominal support, or a corset is indicated. Such an appliance is for temporary use only since it merely prevents strain on the weak muscles. They

must be built up through graduated exercises to hold their own. At the same time exercises are given to stretch the contracted tissues. The support is also of benefit in retaining the corrections obtained through the prescribed movements. In some cases it is advisable to strap the pelvis to prevent shifting and insecurity of the low back. It is emphasized that each patient is an individual problem and should be treated as such.

In summary, it is pointed out that the spine must be kept balanced during the years of growth in order that slight curvatures may not develop into structural deformities, with permanent anatomic changes. Once structural changes have been produced, full correction is never accomplished and improvement is often most difficult to obtain. Parents should be on the lookout for changes in the posture of their children, and patients with curvatures should be impressed early with the fact that long and careful training is essential for both the gaining and the maintenance of correction of their spinal deformities.

A Playroom in a Child Health Center

By FRANCES P. SIMSARIAN

A playroom equipped with proper toys and in charge of a worker who understands child development is a valuable educational tool in a child health conference

THE IDEA that the preschool child should have toys to play with while waiting for the doctor, whether it be in the physician's private office or in the child health conference, is not a new one. The tendency has been to provide the toys pretty casually with all too little thought as to the type of toys or how the parents and children use them once they are provided.

Throughout the past year, an experiment has been under way in the Child Welfare Center at Children's Hospital, Washington, D.C., involving the use of a playroom at the preschool health conferences. The program has been the direct responsibility of the writer, who has been associated with the center in the capacity of psychiatric social worker in the Habit Clinic. The playroom program has thus been part of a larger mental hygiene program, but its contribution has seemed to be sufficiently distinct to warrant separate discussion. One year has been a relatively short time for such an experiment, but to those of us involved, the results this year have been exciting enough to make us feel that we want to keep on experimenting.

The decision to set aside a room for a playroom and to have a worker giving full time to it during the hours that it is open to the children replaces our former more casual policy of providing a few toys when we had them available. Along with it goes a continual stock-taking as to what this new project means to the entire child welfare program.

The aim of the child welfare program is to promote the healthy growth of the child. Formerly this was considered only in terms of his physical growth; today we are coming more and more to the realization that physical and psychological growth go hand in hand. In viewing the development of any child, we have as a minimum three factors to consider: the child himself, his parents and his whole family group, and finally ourselves—what basic knowledge we have to bring to his aid and how our own attitudes assist or hinder us in our desire to help him. An evaluation of the playroom may well begin around its usefulness to these three individuals or groups.

VALUE TO THE PARENT

What has our playroom meant to the parents who bring their children to the center? The fact that the playroom is there is an important step. Parents in general are not aware that play is important for children; that it is in fact the child's first stepping-stone into life. The playroom gives as it were an official sanction to play. It seems to say, "We feel that your child's play is to be respected. More than that, it is vitally important to him."

The playroom had not been open long before we realized how many parents cannot let their children play. Some parents at first refused to have their children come into the room at all. These were frequent comments: "He is too rough to be in there with the others.

He will break everything up." Often a reassurance that we had no breakable toys and that we were used to active children helped. Sometimes it did not.

Other frequent comments were: "He's all right. He will sit right here beside me." Or else, "I tried to get him to go in but he's too shy." In the latter case, whenever possible we invited the mother to sit in the playroom with the child, and encouraged her to remain aloof from the child's play. Often it helped to say to the parents, "The playroom is here so that the children can begin to learn to play with one another while they are waiting for the doctor."

The usual pattern, however, was for the child to undertake play only to be interfered with by the parent, who would either want to show him how to use a toy or would correct him more or less violently whenever there were any aggressive contacts with another child. Throughout, an effort has been made to help the parents change this attitude. They have been reassured about the worker's attitudes toward fights and have been told that a child can learn more through the actual give-and-take experience of play than through correction. An effort has been made to interest the parents in observing rather than participating in their children's play. The year has seemed to bring healthy changes in attitude. More and more we are hearing the comments: "It is interesting to see the way they play, isn't it?" Or, "I think children learn a lot from playing together." How much these changes in attitude that we see in the center are carried over into the home remains to a large extent a matter of speculation because of the difficulty in formulating an estimate—either qualitative or quantitative—of something so subtle as parent-child relationships.

The playroom was equipped in the beginning with fairly expensive non-breakable toys of the usual play-school variety such as blocks, color cones, small

carts and cars, nested blocks, peg boards, dolls, and animals.

As the mothers brought their children they became interested in the various toys and wanted to buy them. In many instances they were beyond the family's means. This has led us to stock the playroom more and more with ten-cent or homemade toys that are educationally sound. We put on an exhibit of these toys; but in the end, the playroom full of children using them is the best exhibit, and the mothers have never been unaware of the toys. We have helped them by preparing a list of toys they can buy or make inexpensively and have devoted considerable time to talking with the parents about the toys. The basic equipment of the room has been simple—chairs, a table, a few shelves for books, and a chest in which most of the toys are kept. This equipment could be made or provided at small cost and would fit into a home. Insofar as possible, the children have been encouraged to return their toys to the chest before leaving. This has often been a task in which the worker has coöperated and many mothers have seemed to observe how smoothly it can be carried out.

Finally, the playroom is easing the conference visit for the parents as well as for the children. After the playroom had been closed during the vacation, one mother commented to the worker on the next visit: "I certainly am glad to see you back. When the playroom isn't open, I run my legs off keeping track of my two."

BENEFIT TO THE CHILD

Considered from the point of view of direct benefit to the child, one must be more tentative in judging the playroom, without at the same time minimizing its effect. As in all other things in life, it is the well adjusted child who gains the most. It is he who is able quickly to adjust to being apart from his mother. It is he who finds the keenest delight in discovering the joys of using crayons or



Blocks, peg boards, and large wooden beads are favorites with the preschool child

stringing beads for the first time. It is he who loves to hitch and unhitch the trains and work with another child in building a block tower. The playroom, as we have used it so far in our center, is a very casual experience which cannot be compared to a nursery school experience. The child may be in the playroom for only a few minutes, or he may be there for two hours. He comes infrequently, usually once every three to four weeks. He has little opportunity to play with the same group of children.

Within all of these limitations, however, there are things that can be pointed to as definite changes in children's attitudes because of the play experience. We all know that a visit to a child health conference is a dreaded experience to many children, to which each reacts according to his personality. The reason lies, at least in part, in the unpleasant experiences that have been associated with it—pokes and injections and all of the inevitable procedures that come with having good physical attention.

More and more the mothers are saying: "He has been talking continually about the toys here. He used to hate to come in. Now he asks to be brought."

A striking example of this was a child who was extremely fearful about coming to the center—housed as it is in a hospital—after he had been hospitalized with a long and painful illness. On his first visit, he clung to his mother, whimpering, afraid that he was going to be left. When the mother sat in the playroom, he was willing to stay, and gradually ventured into play with the other children. On successive visits he has come more and more freely and is now very "outgoing" with the worker. He is one of the best artists who visit the room. Certainly there are many other factors that have operated in the change in his attitude, but the playroom has been a contributing one.

ENLARGES CHILD'S CONTACTS

Contact with mothers and children in the playroom focuses one's attention



Building toys—whether purchased or homemade—offer an outlet for creative energies

upon the extreme limitations in social contacts for many families in the low-income brackets. Children in primitive tribes or in simple communities have the experience of being cared for by many different adults while they were yet quite young.¹ They learn that the world affords many loving arms. Many of our children today grow up far away from grandparents and aunts and uncles. They may seldom even see their father when he must work from dawn to dusk. Small wonder, then, the mother's complaint, "He is so afraid of people." Even the child's casual contact with the worker in the playroom is nonetheless a contact with another adult who is kindly and sympathetic.

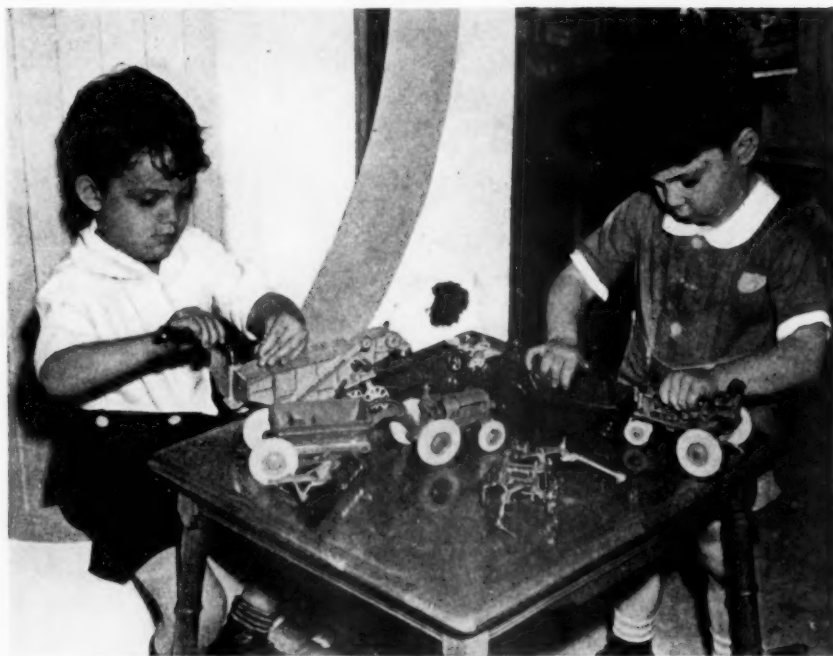
Often Mary will leave the playroom frequently to show each delightful new toy to mother, or just to make sure that mother is still there. Gradually, perhaps

during the course of the first hour, or perhaps only after two or three visits to the playroom, she will begin to turn to the worker. This for Mary is a psychological step. Similarly, many Marys and Johnnies, even when they are three or four years old, have had all too little contact with other children. It is a hard experience for them to find that Billy already has their favorite chair, and that even crying about it is not going to make Billy get out. To be sure, one hour a month is not very much time in which to learn these important lessons, but it is something. And if mother learns too, John and Mary may have more chances for free play.

VALUE TO CONFERENCE STAFF

Finally, the playroom may be considered from the point of view of its value to the staff of the child health conference. It is valuable first because it affords a chance to see children in their ordinary give-and-take functioning. All too often the children become

¹ Sait, Una Bernard. *New Horizons for the Family*. The Macmillan Company, New York, 1938. See page 60 for further elaboration of this point.



Small cars and carts that children can manipulate themselves are always fascinating

to us so many children to be vaccinated. This is inevitable. We are seeing the children always in an abnormal situation. Even in our home visiting, we are not seeing children in quite as normal a situation as we often think. In the first place, we are many times forced to visit the home when the child is asleep and we do not actually see him functioning. We have only a secondhand account of him. Secondly, we must always realize the fact that our visit introduces an unusual factor. A child is rarely his true self in the presence of an outsider, particularly if he is aware—and he is much sooner than we think—that he is the subject of the conversation.

This is not to say that we have a completely normal or usual situation with the children in the playroom, but in many aspects we approach such a situation perhaps as much as we can hope to. The average child will talk more surrounded by toys and other children than in any other situation. We have a chance to learn not only whether he is

talking, but whether he is talking as clearly as one would expect. We can see whether he uses his right or left hand; and if he seems to be left-handed, we discuss it with the mother. This is important because many mothers, feeling that left handedness is a handicap, make an effort to change it—unaware that such a change often has serious neurological implications. When the child is at play, particularly if he is a young child, there is a chance to observe his walking. All too often this slips our notice because the child is so often carried.

On repeated visits, we can begin to form an opinion of the child's probable mental level, to be checked further if there is reason for it. In the more psychological aspects of the child's development and the parent-child relationships, our observations in the playroom have perhaps unique value. Always we believe that what we *observe* about the child and his reactions to his parents has more validity than the things that

we are told about him, providing of course that we do not reach hasty conclusions from one or even two or three observations. Children as well as parents have moods and off days.

A mother may complain that her child is nervous or hyperactive. She may even point to his playroom activity: "Look at him now. He's never still. He's always climbing. He gets into everything and wants to throw whatever he lays his hands on." On the basis of our prolonged observations of children in the playroom, we can tell the mother that this is not nervousness but normal activity for a boy or girl of the child's age. Often she can see this for herself as she watches the other children.

Again, her complaint may be that her child will not play with other children. Perhaps we can reassure her that he has not yet reached the age when one would expect real group play to develop and can show her how this is true of the other children of his age in the room. Or we

may see that the difficulty is with the mother who allows her child to turn always to her. Perhaps she cannot quite seem to let him leave her even for a few minutes. Naturally, under these circumstances he will not play with other children. Again a mother's complaint that her child is selfish, aggressive, and will not share his toys, may seem after observation to be a complaint about very normal childhood activity.

The value of the playroom to the staff lies in the fact that it helps them to gain a concept of what constitutes normality in the field of a child's social development. No amount of reading, even if it is done very wisely, will give a real flesh-and-blood picture. Similarly, observations of our own children or those of other people may give a one-sided or selective picture. In the playroom, there is an opportunity to observe the children with whom we are working, in their own social group. Similarly there is an opportunity to observe the emotional tone

Playing doctor is fun especially with a doll and a few "grown-up" supplies



of the relationship between the child and the parent. Our ability to help this particular parent is increased as we understand him better.

NEED FOR FLEXIBLE PROCEDURE

Our year of experimenting does not in any sense leave us with the feeling that we have evolved a static procedure as far as the use of the playroom is concerned. We have had only a small amount of space available. An ideal room would be a large one opening on to an enclosed porch or court that would give an opportunity for sand box play. Screen doors on the playroom would afford a chance for the children to be reassured that mother is still there, and for the mothers to observe the activity in the playroom. Such doors would, however, separate the mothers and the children, allowing the children to turn to each other in their play.

The fact that the playroom is in the center sets limitations upon some of the types of toys that can be used. We have not wanted to tell the children that they must be quiet, but we have eliminated some of the more noisy toys. We found at first that if the children played hard for an hour or more, they tended to be tired and perhaps overstimulated when the time came to see the doctor, thus making the examination more difficult. Consequently, we have learned to watch the tempo of the play and to introduce

quieter activities as the children show signs of fatigue or as the time to see the doctor approaches. A drawing to show the doctor or a string of beads to wear often makes leaving play easier.

So far, the social worker has been the one person responsible for the playroom. There are both advantages and disadvantages to this system. Under such a plan, the person responsible has an opportunity to grow in her ability to do this particular thing. It gives a consistency to the program in the sense that she has a chance to build up a relationship with the children as they come from time to time. There is more chance to experiment with different methods and to gauge an individual child's progress. The disadvantage of course is that the contact of the rest of the staff with the room is rather casual. However, they have an opportunity to observe the children at play and to discuss individual children as well as some of the playroom activities in conferences.

Certainly the decision to have a playroom in a center should come only after the program for physical care is well organized. As has been pointed out, however, it seems to us to be a valuable supplement to physical care. In the extent in which it increases our understanding of parents and children in general as well as of a particular parent and child it both speeds up and augments our ability to help them.

PROGRAM IN ADVANCED MATERNITY NURSING

The Maternity Center Association, in coöperation with the Department of Nursing Education of Teachers College, announces a two-months' program of advanced maternity nursing for a limited number of maternity supervisors in the field of public health nursing. It will include lectures on obstetrics, community maternity nursing, and other subjects affecting the care of maternity patients; supervised field observation; round-table discussion of administrative and other problems, and assigned reading. For information, write to the Maternity Center Association, 654 Madison Avenue, New York, N. Y., giving name, address, and present position.

College Health in the Black Hills

By BESSIE E. OAKES, R.N.

A teachers' college on the western plains prepares its students to safeguard their own health and to supervise the health of the children for whom they are responsible

BLACK HILLS Teachers College in South Dakota is a college of 291 students drawn largely from the sheep and cattle country of South Dakota and Wyoming. Forty-four percent of the students are boys. The faculty numbers thirty-two. The college is at present in the throes of transition from a two-year to a four-year curriculum.

Since its beginning in 1885, the college has had the part-time services of a physician. The present college physician taught physiology for several years, and although not teaching at present he is still on the faculty as the school physician. Since 1918 the college has had the full-time services of a graduate nurse, but only since 1934 has the nurse been one with university preparation in public health and education. She now bears the title of health supervisor, with faculty ranking in the Administration Department. She is the only full-time person in the health service.

THE HEALTH COUNCIL

In order to integrate the health program, to insure its comprehensiveness, and to study the health needs of future teachers with curriculum changes in mind, a health council was organized in January 1939. Its membership is composed of the superintendent of the training school as coördinator, the academic dean who is head of the Education Department, the dean of women, the primary and upper-grade supervisors of the training school, the instructors in phy-

sical education and physiology, and the nurse.

Health education in a teachers' college logically divides itself into two phases: guidance and health instruction of the students for personal well-being, and preparation for teaching health.

HEALTH EDUCATION

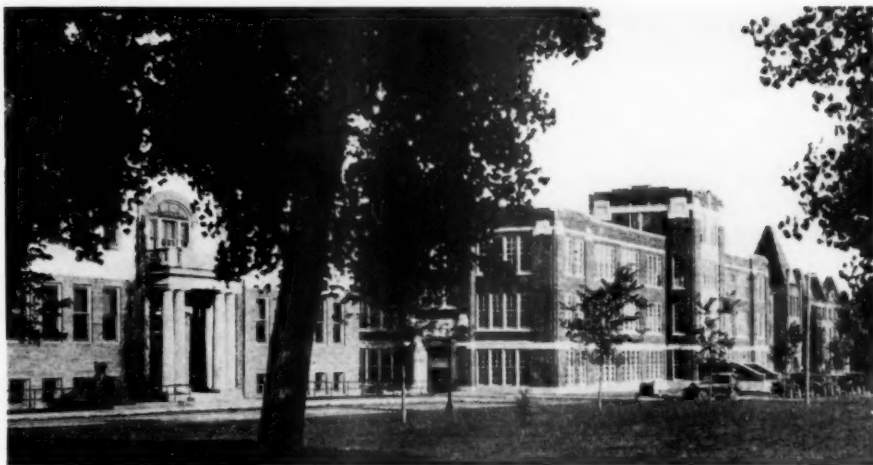
There are no definite health courses in the college curriculum at present. However, in view of the plans for a four-year school and ensuing changes in the curriculum, emphasis has been placed during the past year on creating rapport and developing a better knowledge of health education among the members of the faculty and administration. For it is only through group planning and direction that an integrated program can be built and made to work efficiently.

Pending the adoption in the curriculum of definite instruction in hygiene and health teaching procedures, the following plan worked out by the Health Council is proving effective and worth while:

Health education lectures and demonstrations are given by the nurse in the following related courses:

- Primary activities
- Principles of education
- Principles of physical education
- Physiology
- South Dakota curriculum

The lectures and demonstrations include the following subjects, which are placed in the above courses in the se-



Black Hills Teachers College

quence in which they will be most effective:

Defects and their relation to mental and physical growth

Vision and hearing tests

Schoolroom inspection

Communicable diseases in the school

Healthful school living, with emphasis on environment and the school day, and with demonstrations of projects which might be worked out in a rural school

During the 1939 summer session a course in physiology and hygiene was taught by the nurse. Its aim was to help the teacher obtain a broader scientific knowledge of health facts and their practical application in relation to problems which the teacher on the western plains must face alone, miles from the aid of physician or nurse. Needless to say, it was possible to touch only the high points in so short a time. But the students in this class, nearly all teachers of experience, proved that they need and want health instruction which will be of practical value to them in the classroom. The college hopes soon to meet that need.

The school paper, published every two weeks, gives space to "Health Hints," emphasizing important points in health.

All students are introduced to the medical service during registration week, when they receive their physical exam-

inations. This examination includes the heart, chest, throat, skin, eyes and vision, height and weight, motor ability, and posture tests. The examination is made by the physician, with the assistance of the nurse and physical education instructor. Appointments are made for a further examination at the physician's office when the findings indicate that it is needed. Last year six students were excluded from athletics and five were excluded entirely from physical education as a result of the examination. Nine were assigned to corrective classes. Five were permitted to take only a limited class load for the first quarter. Follow-up work on the examinations is done by the nurse.

Mantoux tests are given early in the year by the physician to all entering students, faculty, and personnel of the college. The material is furnished by the State Board of Health. X-ray pictures of positive reactors are made, usually at the state sanatorium for the sake of efficiency and reduced cost. The cost is paid by the student. Transportation is taken care of by the student.

There is no student health fee. The cost of the service is provided for in the educational budget. The medical service furnished by the college includes:

1. Consultations, advice, prescriptions, and minor treatments as frequently as needed, at the infirmary or the physician's office.

2. Medical service and x-ray pictures in case of injuries in athletics.

3. Care of seriously ill patients in nearby hospitals of the student's choice and at the student's expense. Care of short or minor illnesses in the college infirmary free of charge. The infirmary is equipped with three beds, bathroom, and treatment room. A separate room is being equipped this year for more adequate isolation of communicable disease. There is space for five additional beds.

4. Physical examinations of all students.

5. Mantoux tests and immunization of students and personnel for smallpox and diphtheria.

THE NURSE AS HEALTH SUPERVISOR

From the first day of school till the last, the nurse endeavors to make each contact with the students and faculty a learning situation. She lives in the college dormitory for girls, in which the infirmary and health office are located on the first floor. This arrangement is advantageous from the standpoint of health supervision as it brings about a close relationship between students and nurse.

At present the nurse and the house council, composed of representatives from each class, are making a drive for better budgeting of time for study, rest, and recreation. The administration believes that future teachers should be guided to govern their own lives intelligently. When this is accomplished, they are ready to lead others.

The close association between the faculty and students of the college is valuable, for the faculty are thus able to notice strains upon the student's health which might otherwise escape notice. Consultations between the faculty and nurse in these matters are increasing in frequency and value.

STUDENT CONFERENCES

During the first few weeks of school all students are given appointments for ten- to twenty-minute conferences with the nurse. In this conference the student's physical examination is interpreted. Personal problems, defects and their correction, and budgeting of time and energy are discussed, and appointments are made for further medical and nursing care if needed. These individual conferences serve as an orientation in healthful living, and our experience indicates that they are an important factor in forming good health habits. Many of the entering students have never had personal contact with a physician or nurse before.

The student who is absent from class must obtain a readmission slip from the nurse. The health office is open for this purpose and also for general health conferences, following each meal. Meals are sent to rooms only if illness is reported to the nurse one-half hour before mealtime, and readmission slips to class are issued only if illness is reported at its beginning. This rule is questionable from the standpoint of self-direction, but it has been found essential in order to guide the new student into the right habits of living. It promotes early reporting of illness, thus reducing the spread of colds and communicable diseases.

HEALTH IN THE TRAINING SCHOOL

The training school at the college provides many opportunities for health education of student teachers. The physical examination given to all pupils entering the training school; the careful follow-up work for the correction of defects; the height and weight records kept in all grades, with emphasis on growth; the health reports sent to parents with the report cards; the mid-morning milk given to children with nutritional needs; the hot lunches; the health activities in all grades; the health



The growth record becomes a lesson in arithmetic and an incentive for health habits

teaching coordinated in social and general science in the fifth to ninth grades—all these have distinct educational value to student teachers who are having their observation and practice teaching.

Consultations are given freely by the nurse to critic and student teachers on health matters. Special health talks on subjects in which the children are especially interested are given on request. One student teacher recently proposed a health project for the eighth grade in the form of a first-aid kit for a rural school. The boys in manual training class will make a small sectional cupboard to hang on the wall, while the girls will be taught by the nurse how to make the supplies and sterilize them on the school stove. The class proposes to donate the kit to the school for demonstration purposes. This project shows constructive thinking along health lines.

During the school year the nurse has two student assistants who help with infirmary care, projects, demonstrations, training school routine, clerical work, and other activities. This is a coveted position since the students believe they receive instruction which is helpful to them personally.

During the school year the nurse is assistant to the dean of women. The health work is, however, given precedence. During the summer, in the dean's

absence, the regular health service is discontinued. The nurse takes over the duties of acting dean and teaches one class in physiology. Extra nursing service is provided from local sources if needed. The nurse's work in the dean's office provides opportunities for service in the mental health program, discovering students with emotional problems and helping them or referring them to proper services for help.

THE COMMUNITY

The small college is a part of the community life around it. Due to the fact that Lawrence County and the town of Spearfish have no public health nurse, the nurse at the college gives occasional health talks and demonstrations to community organizations. These organizations in turn cooperate with the school and nurse in:

Making possible the correction of defects to needy students in the college and pupils in the training school.

Sending children to a summer camp.

Furnishing milk to children with nutritional needs, in the training school.

The health program in Black Hills Teachers College begins with personal hygiene and broadens out into school and community hygiene, thus creating a concern for the welfare of others which every future teacher should have.

Three Frontiers in Public Health

By WILBUR A. SAWYER, M.D.

Recent research on yellow fever, malaria, and influenza is described by the director of the International Health Division of the Rockefeller Foundation

THE FRONTIERS IN public health are the advancing edge of that knowledge which is necessary if communities are to protect themselves against disease and attain a maximum degree of physical well-being. These frontiers are wherever earnest workers are striving after needed facts, or experimenting in their first application to community problems. They may be in the jungles of Africa or in the hearts of our cities; in white-tiled laboratories or in congested tenements. One early frontier was in a house on Henry Street where two valiant and devoted women, Lillian D. Wald and Mary Brewster, pioneered in public health nursing and laid the ground work for the Henry Street Visiting Nurse Service* in New York City.

YELLOW FEVER

The frontiers to be discussed here have not been selected for their importance alone, but rather because of their picturesqueness and the writer's own contacts with the problems and the workers. The first is the yellow fever frontier. There we have recently had such primitive conditions that some of the frontiersmen have given their lives for lack of the knowledge which they were seeking and which has subsequently been attained.

This frontier has been pushed back

in several stages. The brilliant and decisive experiments of the Reed commission in Cuba at the beginning of the century are familiar to all. They could only be carried on by the use of human volunteers. They were followed by a quarter of a century in which little fundamental new knowledge of yellow fever was acquired. There was no known susceptible laboratory animal for experiments and the use of human volunteers no longer seemed justified when the role of the *stegomyia* mosquito in spreading the disease had already been revealed and city after city was being freed of yellow fever.

The Reed experiments and the successful control of yellow fever by Gorgas and others did not close the yellow fever drama, for there was still a great unsuspected unknown. The belief that the disease could be endemic only in cities and that it could be spread only by one species of mosquito, the *stegomyia* or *Aedes aegypti*, was generally accepted. Nevertheless, persistent attempts failed to exterminate yellow fever in the northeastern part of Brazil by mosquito-control measures in the coastal cities and large towns, and the disease was being found in the interior farther and farther away from urban centers. Moreover, the disease had an unexplainable way of suddenly appearing without any obvious source, as in the cases of the last epidemic in Rio de Janeiro and the outbreak of a few years ago in Santa Cruz in Bolivia.

A new era in yellow fever research

*This paper was presented at the official opening of the Administration Building of the Henry Street Visiting Nursing Service, New York, N. Y., October 9, 1939.

was opened in 1927 with a discovery by members of a yellow fever commission of the Rockefeller Foundation working in West Africa. They found that the common rhesus monkey of our laboratories and zoological gardens was even more susceptible to yellow fever than man.¹ This discovery stimulated yellow fever research in many laboratories and in the field, but not without heavy cost.

NEW RESEARCH COSTLY IN LIVES

Five scientists participating in the studies in West Africa and Brazil died of the disease. There seemed to be no practical and effective method of giving adequate protection to the investigators in those early days, and there were times before such a method was discovered when it seemed that the work might even have to be discontinued.

A hero of the early stage of this scientific venture was Dr. Adrian Stokes.² When he realized that he had been stricken through some unsuspected laboratory exposure he insisted that mosquitoes be fed on him so that the disease could be passed from a typical human case to experimental monkeys in the natural way, thus proving beyond any doubt that the experimental disease in monkeys was true yellow fever. Dr. Stokes' scientific aim was achieved but his participation in the important experiments was interrupted by his death.

But there was no longer any lag in yellow fever experimentation. In 1930 it was discovered by Dr. M. Theiler in Boston that the white mouse was also susceptible if inoculated in a certain way.³ With these two animals—monkeys and mice—many revealing studies were carried out. By testing the blood of persons for its power to protect mice or monkeys against yellow fever it was possible to tell whether these persons had ever had the disease. The serum of persons who had had yellow fever seventy-five years earlier

in Virginia was still able to protect animals against yellow fever virus from Africa. One of the soldier subjects who had yellow fever in Reed's experiments contributed blood which protected mice against yellow fever virus thirty years after the soldier's attack.

By testing serums collected in many countries it was found that the infection had recently existed and was probably still present in Africa from Senegal to the upper Nile, although it had not previously been identified in Central Africa. Likewise it was shown to be present in most of the Amazon basin, although it was supposed to have disappeared from there many years earlier. The greatest surprise came when field studies with laboratory help identified outbreaks of yellow fever far in the interior of South America in localities in which the well known aegypti mosquito which transmitted yellow fever in cities was entirely absent. It was discovered that this yellow fever of the interior was contracted chiefly in the forest environment where there were few people to keep the virus alive. Vigorous young men who worked in the forests were the ones chiefly affected while the women and children who stayed out of the forest escaped.

RESERVOIR OF THE DISEASE FOUND

The location of the great reservoir from which yellow fever came into cities and paths of commerce to start epidemics had been found, but its nature is not yet wholly revealed. Blood tests of wild monkeys show that they are involved in the epidemics, but other animals may also play a part. The capture and testing of thousands of forest mosquitoes during an epidemic of jungle yellow fever showed that three species had yellow fever virus in them and that two of them could transmit yellow fever to monkeys by biting.⁴ Studies are still going on in many places in South America and Africa and it is

confidently expected that the epidemiology of jungle yellow fever will ultimately be fully revealed.

The deaths and illnesses of the early laboratory workers and the impossibility of applying mosquito control to jungle yellow fever made it urgently necessary to find methods of immunization. This was finally accomplished by giving single injections of modified living yellow fever virus. At first the method was such that it could not be used on a large scale and only persons specially exposed could be immunized. As a result the laboratory and field investigators and many others have been completely protected since the procedure was first started in 1931.

More recently the virus has been still further modified by prolonged cultivation in tissue culture until its virulence has been almost completely lost.^{5,6} With such virus one and one-half million people have been vaccinated in South America for protection against jungle yellow fever and additional thousands have been protected before exposure in Africa. The yellow fever frontier has been pushed back until much of the terror has been removed from that fearful epidemic disease which used to invade the United States.

MALARIA

Malaria may be said to have many frontiers, for it is transmitted by numerous species of anopheles mosquitoes and each has its own peculiar habits and environmental preferences. Accordingly studies on one malaria frontier still leave it necessary to make similar investigations on the others. Methods have to be sought which are not only effective locally, but which are also within the financial resources of the community.

While malaria is ordinarily endemic it occasionally develops into a devastating epidemic, and one of the malaria frontiers of today lies in the northeast-

ern part of Brazil where such an epidemic is now being studied and fought. In 1930, Mr. Shannon,⁷ an entomologist of the yellow fever service, was satisfying that great curiosity common to all true biologists by collecting the local mosquito larvae at Natal, breeding them out, and classifying them. He found an anopheles which had never been reported from the Western Hemisphere, and identified it as an African variety, *Anopheles gambiae*. The then limited distribution of this mosquito, the subsequent sudden increase in the amount of local malaria, and the later spread of the mosquito to a larger area all suggest that the insect was a new arrival in the Western World. It seemed most probable that it had come over from Africa in the larval or adult stages on one of the fast French mail steamers which connected with the airplanes at Natal.

The next month after the discovery, there began in Natal an outbreak of malaria of unprecedented severity. By dissection 108 out of 172 captured gambiae mosquitoes were found to be infected, showing that this mosquito had the same high efficiency as a malaria vector in Brazil as in Africa. Since then gambiae has spread, in spite of local control activities, for 300 miles to the westward, in the direction of the prevailing winds. It is still in a region of relatively low rainfall with long, dry seasons. As a result it is limited in its spread to following the coast and going up the river valleys.

Last year the seriousness of the situation was made evident by a survey of the involved area. Towns which had been recently invaded were hard hit. There were many deaths due to malaria and a sharp rise in the annual total death rate. While malaria of the two common varieties attacking man had probably always been present in the region, the indigenous local anopheles had been relatively inefficient as ma-

laria transmitters. Many persons had previously escaped the disease and were consequently highly susceptible. With the arrival of gambiae in great numbers the conditions were ripe for a severe epidemic.

Something more than palliative control and medication had to be done, and quickly. It was predicted that if the mosquito reached the well watered Amazon basin, it would be impossible to prevent its spread over the greater part of South America and perhaps to Central America and parts of our South. To permit gambiae to establish itself firmly in the Western Hemisphere might spread the devastation observed in northeast Brazil to many communities and might ultimately have a permanent adverse effect on the welfare of millions of people. It seemed worth great cost and effort to attempt against heavy odds to get rid of the new invader while it was still possible.

CONTROL PROGRAM UNDER WAY

Accordingly there is being developed by the Government of Brazil and the Rockefeller Foundation an investigation and control service for the primary purpose of eliminating this mosquito. The estimated cost will be great. Much will have to be learned about the mosquito in its new environment, and methods of fighting it in the several stages of its existence will have to be tested and perhaps invented. Over 1700 men have already been employed, and control work is rapidly getting under way with particular emphasis on the gambiae's own frontier, beyond which an uninhabited zone about ten miles wide will be made uninhabitable for this mosquito, if possible. Pools are being filled in and Paris green is being spread on the breeding places. Trains, automobiles, and trucks are being treated with insecticides at quarantine posts. The regions of special interest will be photographed from the air and carefully

mapped so that no places requiring drainage or other treatment will be missed. The size of the undertaking will be realized when one considers that the infected territory contains over 12,000 square miles.

The scientists and numerous employees find it necessary to take prophylactic drugs systematically to avoid being laid up with malaria under the existing severe conditions of exposure. Nevertheless several have already experienced attacks. Before long, however, the work in eradicating the mosquito should begin to have its effects and lighten the troubles of these frontiersmen. In the meanwhile many inhabitants have to be treated for malaria as a relief measure. In the first half of this year 114,000 were given medication for malaria by the gambiae service.

INFLUENZA

A third and last example of a public health frontier is the advancing front of the knowledge of influenza. This frontier is very close to us. At times the disease is almost everywhere, and it is especially widespread in the temperate zone. New York City is an important center for research on this disease. Influenza has always moved about without hindrance, for there has never been any effective method of control because there has been no adequate understanding of the causation of this disease. Even today influenza, as the term is usually applied, is a vague combination of disease symptoms, usually with involvement of the respiratory tract, classified as influenza when no exact diagnosis will fit. Such a situation can hardly be escaped until the principal communicable respiratory diseases now called influenza can be identified and separated on the basis of their causation.

The important beginning was made in 1933 when Smith, Andrewes, and Laid-

law, in the National Institute for Medical Research at Hampstead, England, succeeded in transmitting the infectious agent of one type of influenza then epidemic in England to ferrets by dropping throat washings from human patients into the noses of the anaesthetized animals.⁸ The same virus was similarly isolated in the following years in outbreaks of influenza in many countries, from Alaska to Puerto Rico and from the United States to Central Europe and Australia. This virus was transmitted to mice also, but the ferret is the more susceptible and mice can be used only in certain types of study. This infectious agent of one of the influenzas has been identified as a filterable virus and its properties are being thoroughly studied. The disease which it causes has been named epidemic influenza, the first disease to be defined and separated from the vague influenza group. The scientific studies now made possible have already shown that at least one very definite outbreak similar to epidemic influenza was not due to the virus of epidemic influenza, and should be considered a separate disease.

In the case of a disease so highly

communicable through personal contact as is influenza, the obvious need is for a method of immunization for purposes of prevention. It still remains to be seen whether a method of producing an effective and lasting immunity can be devised. Many workers are searching for the answer and it is hoped that it will be at hand before another influenza pandemic begins.

Sometimes the writer hears it stated on impressive authority that medical science has advanced so far that what the world needs now is the application of what has already been discovered. The implication is that we know almost enough and need only organization and publicity. To discover the limitations of this half-truth one needs only to try to work on a large scale in the prevention of any disease. Almost at the beginning there will arise fundamental questions which must be answered if our procedures are to become practical and effective. Quickly we have to turn again to those pioneers who are clearing away ignorance at the frontiers in public health or are experimenting in limited communities with the trial application of the newer knowledge.

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HENRY STREET'S NEW HOME

By
MARY
SCHIEFFELIN
BROWN



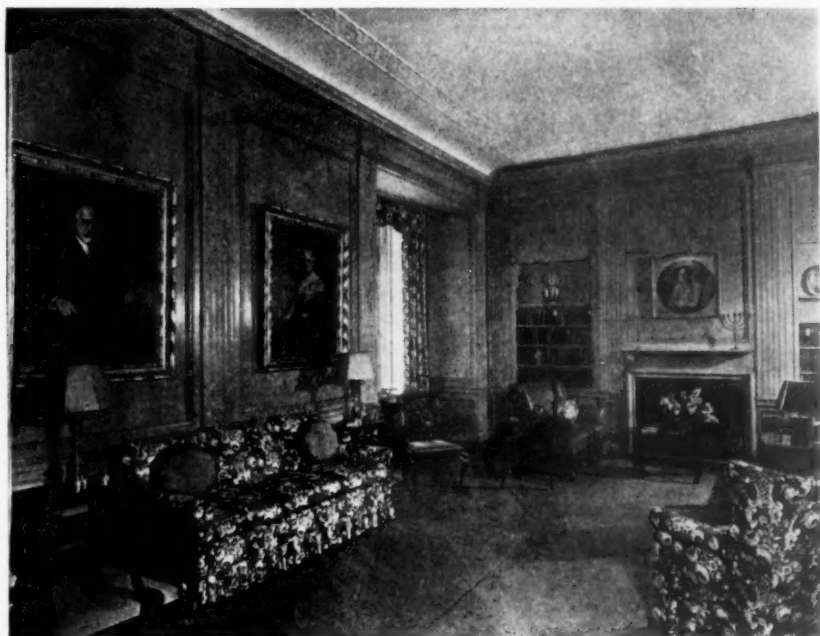
THE Henry Street Visiting Nurse Service is established in its beautiful new Administration Building at 262 Madison Avenue, where the directors, Nursing Committee, and staff love to welcome friends, old and new.

There is a story behind this building. After the death of Jacob H. Schiff, whose generosity had provided Lillian D. Wald with the original "House on Henry Street," his wife gave the central Administration Building at 99 Park Avenue in his memory, for the use of the nursing service. This was in January 1925. In May 1937, the city condemned the building and bought the site for a courthouse, making it necessary to replace this memorial gift. With the money paid by the city for the property, the new building was purchased, altered, and equipped.

Hundreds of nurses who have been with the Henry Street Service during the years will remember "99," as will many

distinguished visitors who came there to gather material, to study the methods of the Service, and to offer their experience to it. While it was a wrench to leave "99," the city's action making the change necessary actually proved a blessing in the end. For the growth and development of the Service during those twelve years meant that our quarters had become very cramped, and we were badly in need of more space. For a year a building committee worked with the architect on the alterations of the new house; our decorator, with talent and ingenuity, gave it distinction at little cost; the executive staff spent hours working out the needs of their departments; and finally in the last week of April 1939, we moved in.

The beautiful assembly room, used for staff meetings, campaign meetings, and many other functions, has the fine pegged floor from the big room at "99." It also contains the memorial mantelpiece whose



Lillian D. Wald room

inscription, worded years ago by Miss Wald and her friend Jane Addams, closes with these words defining the purpose of the building, "... dedicated to the cause of Public Health Nursing which he long fostered for love of Progressive Education, Civic Righteousness and Merciful Ministration."

There is a board and committee room which was a crying need, and a charmingly furnished sitting room, which is in frequent use for small nursing groups and for entertaining visitors. This is to be known as the Lillian D. Wald room, and Miss Wald's portrait is over the mantel, while the portraits of Mr. and Mrs. Schiff hang on the wall. The offices are as well arranged as thought and ingenuity could make them, and with their great windows they are bright and cheerful. Two rooms are assigned to the student and staff education programs—one a large demonstration room and the other a conference room for smaller groups.

The restaurant at "99" was a delightful place, beloved by the whole neighborhood, and almost historic by virtue of the interesting and important conferences that took place over its delicious meals. However, for a number of reasons, chief among them the fact that we could not spare the space, we did not include a restaurant in the new building. But there is a bright and attractive staff room on the top floor with kitchenette attached, where the staff in the building may heat soup or coffee and eat their lunches.

Our aim, that the building should provide dignified and practical headquarters for the nursing service and should be a fitting perpetuation of the memorial gift, has been accomplished. We hope that former Henry Streeters and other members of the National Organization for Public Health Nursing will come and call when they are in New York. A warm welcome always awaits them in our new home.

Securing Early Antepartum Care

By MARION A. FLUENT, R.N.

An analysis of the role of the public health nurse in achieving the early registration of prospective mothers for medical supervision during the antepartum period

VARIOUS STUDIES indicate that women are not availing themselves of medical care as early in pregnancy as is necessary for the safety and optimal health of mother and baby. A study published by the Metropolitan Life Insurance Company in June 1939 shows that in two groups considered—2300 women in the urban area of Greater New York City and 3400 women in five southern states—approximately 50 percent of the first antepartum visits to the physician were made in the last trimester of pregnancy, 40 percent in the second trimester, and only slightly over 10 percent in the first trimester.¹

Somewhat more encouraging are the figures shown by the Chicago Lying-in Hospital and Dispensary in a review of their admissions for 1938. Approximately 40 percent of their patients registered in the first trimester, 43 percent in the second, and 17 percent in the third.² This study, however, did not include the relatively small number who were admitted on an emergency basis nor those patients who were registered in the outlying clinic for home delivery.

A study in Cattaraugus County, New York, from September 1929 to June 1932 showed that 31 percent of the mothers registered in the first trimester, 39 percent in the next four months, and 9 percent in the last two months, while 21 percent had no medical care previous to delivery.³ Only one half of these women registered early enough to receive reasonably good supervision, and about 20 percent of the total number

who registered made only one visit to the doctor.

WHOSE RESPONSIBILITY IS IT?

This is a picture of the challenge that is presented. Whose responsibility is it to see that mothers receive early antepartum care? Ultimately of course it depends on the patient. As one report states: "... early registration is entirely in the hands of the expectant mother, and until the public generally recognizes this fact we cannot expect to secure the greatest possible benefits from prenatal care."⁴

Teaching mothers the importance of early medical care is considered an important function of the public health nurse. Rather startling, therefore, is the conclusion appearing in one study: "Case-finding and advice on the value of medical care during pregnancy by the nurses had been a very small factor in bringing patients in this series under medical supervision."⁵ This statement is strengthened by figures which show that 20 percent of the women who had been given nursing supervision in previous pregnancies did not seek medical supervision—practically the same percent as that for the group as a whole.⁶ From this finding the conclusion was drawn that previous education of mothers by nurses "had not effectively modified the current attitude toward the need for medical care."⁷

This situation is significant for both urban and rural areas, since both share in its implications. We in centers of dense population cannot shrug our

shoulders at the picture and say, "It is a rural problem," any more than those in rural areas can make the reverse contention. For a Michigan study in 1936 showed that only one fourth of the women in large cities received health supervision over approximately eight months of pregnancy, as compared with one fifth of the women in small cities, and one sixth of those in rural communities.⁸

This slight variation between different areas shows that there is need for every type of community to work toward a solution of the problem. Nor can there be evasion of responsibility by any group in the community. If it is true that we as nurses need to perfect our methods of presenting the value of antepartum medical supervision, let us not be disheartened by our failure. Let us rather accept it as a stimulus to find out where improvement can be made. Where have our methods been successful? Where have they met with failure? Do we gloss over our failures, or on the other hand become too despondent over them? We have stopped writing "patient uncoöperative" on our records, but have we accepted the full significance of the change in wording and incorporated it in our approach to the families?

We need to be more analytical of our own methods and subsequent results. It is in an effort to stimulate thinking in this direction, rather than to offer a formula for solution of the problem, that the following material is presented. For even if the formula were available, it would have to be adapted to the capacity of each nurse, to the situation of each expectant mother, and to the facilities of each community.

REASONS GIVEN BY PATIENTS

What are the reasons given by women for not seeking medical supervision early in pregnancy? How much do we really know of those reasons? Do we take it for granted that women would go to the

doctor if they had the money? Do we appreciate the possibility of other significant reasons?

In an effort to consider this aspect of the problem, requests were sent to nine agencies, rural and urban, in widely separated areas of the United States, for a sampling of the reasons given by their expectant mothers for not seeing a doctor earlier in pregnancy. The seven agencies which responded sent interesting material on which they had spent much time and thought. The reasons given were classified according to the following general headings:

1. Financial
2. Individual
3. Attitude toward medical care
4. Lack of knowledge of available facilities
5. Inability to recognize need for medical care
6. Poor coöperation between agencies

These classifications were arbitrarily chosen, and there were times when it was difficult to decide under which grouping a certain reason belonged. For instance, one mother said: "I have no one to stay with the children. It takes too long, anyway. We have to wait too long." Was her failure to seek care due to family responsibility, indifference to medical care, or unsatisfactory clinic functioning? We finally classified it as an "individual" reason, under the subdivision, "family responsibility."

Occasionally there was an obvious excuse obscuring a reason which seemed more significant, such as: "No money for private physician. Feared doctors. Had language difficulty. Wished female attendants." This was from a Spanish woman having her third child; and even though there was a financial aspect, the important factor seemed to be an "individual" reason under the subdivision, "nationality custom." In general, however, the statements were clear-cut and fell easily into the classifications.

The headings given above are listed in the order of frequency in which we

expected the reasons to fall. We thought that financial causes would be first. Second in importance we listed individual reasons, such as nationality, cultural factors, or family responsibilities. Next was placed attitude toward medical care, such as having to wait in clinics or dissatisfaction with previous care. Following this, we listed lack of knowledge of available facilities. Perhaps a few would be unaware of the need of medical supervision. And there might even be instances showing lack of coöperation between community agencies.

FAILURE TO RECOGNIZE NEED

A casual survey of the reports showed that the classifications were applicable, but as the tabulation progressed it was necessary to make many more subdivisions than had been anticipated. The order of frequency of the reasons was, however, really astonishing. By far the largest number fell into the class called "inability to recognize need for medical care." Over three quarters of these were due to lack of effective information, and the remainder to indifference. Perhaps the indifference was a result of lack of effective information, but we believed there was a slight difference in the attitudes of the mothers in the two groups as shown by the nurses' descriptions. For instance, a mother in the first group might say that she was following instructions given during previous pregnancies and did not think medical care was necessary, while a mother in the second group commented that she would get along all right and did not see any use in going to the doctor.

The financial reasons made up the second largest grouping—the one we had expected to be first in importance. These probably could all have been attributed to inadequate income, but we were interested in different aspects of that situation. Debt for previous medical care, lack of transportation facilities, employment of the mother, and what

seemed to be unsatisfactory arrangements regarding referrals from the relief organizations made up about a third of this group. The other two thirds simply said they did not go because they did not have the money; their families were either on relief or on the borderline. In one instance in which the family was rated as having the "necessities," the mother who said she did not have the money was classified as being unable to recognize the need. It was particularly interesting to note that out of the total of 450 reasons presented, only 6 were employment of the mother.

INABILITY TO ACCEPT PREGNANCY

The third grouping is that which, for lack of a better name, we called "individual." About one half of these statements showed that the expectant mother was unwilling to accept pregnancy for various reasons. In one case the patient's mother had died in childbirth. "She had a great fear of pregnancy," said the report, "and by not going to the physician she could more or less push it into her subconscious." Another report read: "Ashamed of having another baby, since the doctor had given contraceptive advice. Patient never understood the method very well, and did not go back for more instruction." Again, "Doctor told patient not to have another baby for two or three years because of toxemia, but did not give any contraceptive advice. Within three months of last childbirth patient became pregnant again and was afraid to go to doctor." Still another read: "Ashamed of pregnancy at first. Youngest child was thirteen years of age." And, "Mother not married. No one knew of pregnancy."

A few in this classification should perhaps have been more closely tied up with the financial group. For example, one report stated: "Financially unable to go to a private physician. Would not go to clinic because they had taken care of her one year before and she felt

ashamed to have them know she was pregnant again so soon." A small proportion of the remainder of this group attributed their delay to fear of medical examination, and to lack of understanding and interest on the part of the father. The majority of the rest gave two reasons for not registering earlier. The first was the presence of responsibilities in the home, such as having no one with whom to leave the children, or the sickness of an older person; the second was nationality or cultural custom or prejudice.

ATTITUDE TOWARD CARE

The fourth classification, "attitude toward medical care," included only about seven percent of the whole. Three quarters of these mothers had had experience with medical supervision which left them uninterested in seeking it again. Perhaps they felt they had been subjected to unnecessary waits or unhappy experiences in clinics, or as one mother said of the doctor: "He never did anything I read about in the prenatal booklets, anyway." The women in the remaining fourth of this group were unable to make up their minds as to whether they wanted to register at a clinic and have a hospital delivery, or to wait until they were in labor and then call a private physician and have a home delivery. This difficulty seemed to arise most often in a city where the department of public assistance pays for home delivery only, while the city welfare organization pays for either home or hospital delivery.

It was heartening to find that only 14 of the 450 reasons could be classed as due to lack of knowledge of existing facilities in the community, and several of these were from people who had just moved to the locality.

A correspondingly small number could be traced to poor cooperation between agencies. However, a case was reported in which a mother was attending one

clinic of an outpatient department through the eighth month of pregnancy before she was referred to the antepartum clinic.

These, then, are some of the reasons that antepartum patients give for not seeking medical supervision earlier in pregnancy. They all sound familiar, but they present some definite possibilities for our future thinking.

ANALYZE OUR SUCCESSES

If there are many expectant mothers who do not realize that they can be helped by medical supervision, what can we as public health nurses do about it? We have been working on this problem for years, perhaps the reader will say, and there are people who just will not go. That may be true, of course. But when we have been successful in a situation which seemed particularly difficult, have we taken the time to think over our handling of the case, to see what it was that accomplished results? Were we a little more interested in that family because the house was kept clean under adverse circumstances? Did we make an appointment to talk to the father after he came home from work? Was there a neighbor who had experienced the value of good antepartum care when her last baby was born, and who really clinched the argument for us? The analyses of successes are just as important as reviews of failures. It is something which we need to do for the sake of our own development as well as for the benefit of the patients.

We have found, too, that in communities where there are well qualified nurses teaching in the high schools, there is a noticeable difference in the attitude of young mothers toward pregnancy. They have been given a healthy understanding of reproduction and their part in it. They have an interest in obtaining the assistance necessary for the successful culmination of what they know to be a normal bodily function. More com-

munities should be profiting from the instruction of public health nurses qualified to teach in high school.

Another public health nursing activity which brings excellent results is the series of classes for expectant mothers and fathers. These classes may be in connection with clinics, or they may be given for patients of private physicians. Their content may include lectures, discussions, craft instruction, or demonstrations of baby care. Whatever the arrangement may be, such classes are a stimulating activity for the nurse who has an aptitude for working with groups.

FINANCIAL PROBLEM

The financial aspect of the maternity situation makes us all feel somewhat baffled, to be sure. Probably the most useful service the nurse can provide is that of interpretation. It may be necessary to show the need of the patient to an agency or to a doctor. Perhaps the father can be encouraged to talk to the doctor to whom he already owes a bill; many times a satisfactory arrangement can be reached. If the nurse explains to the father and mother the procedure of the relief agency in making referrals, they may understand why it is necessary to get a letter for each clinic attendance. It is even conceivable that the nurse may be able to show the relief director or the clinic director where their regulations work a hardship for the families.

In communities where clinic services are not available, a lay committee can be of immeasurable assistance in planning a substitute organization. As one state advisory nurse wrote: "Our nurses try never to work alone, but solicit the help of all interested groups. In some counties the nurses have health committees composed of key women from different parts of the counties. We feel that they can do more than we can in spreading the gospel of early medical care for prenatal patients." Both official and nonofficial agencies are increasingly

finding value in the use of these committees. Any nurse interested in their organization will be given helpful information from the National Organization for Public Health Nursing.

The function of the nurse which is probably accompanied with the greatest success is that of helping the mother to think through her more personal problems, such as fear of medical examinations, or unwillingness to accept pregnancy because of dreading the opinion of family or neighborhood. There is an increasing appreciation, too, of the obstacles which can be hurdled by bringing the father into the picture as early as possible, for oftentimes his enthusiasm at being included in the planning makes the difference between success and failure.

The old story of "no one to leave the children with," presents a difficult problem—one which has to be worked out in each situation on an individual basis.

MUTUAL UNDERSTANDING IMPORTANT

The opportunity to interpret social and health services to the family is a great challenge to the public health nurse. It requires a knowledge of the community, an understanding of human behavior, and tact in handling delicate situations. The nurse will make any effort necessary to help a family to secure an understanding of the function and policies of a community agency. If the parents are first allowed to state their feelings unreservedly, they are likely to be in a better frame of mind to accept the nurse's objective presentation of the situation.

The problem arising from the need to carry back to an agency or a physician the viewpoint presented by a patient is handled according to the policy of the agency which the nurse represents. There should be a definite routing of such information according to the administrative policies of the groups concerned. Perhaps each nurse takes care

of the problems as they arise in her district. Or the matter may be referred to the director or the health officer to be taken up with the medical advisory committee, the physician personally, or the director of the other agency.

These misunderstandings do not seem to be a great factor in preventing mothers from seeking early medical care, but there is little justification for their existence at all. An ethical handling of interagency relations, together with a thorough understanding of the policies and programs of all community organizations, will go far to adjust this problem.

The one prerequisite for success in antepartum visiting which has not been mentioned is probably the most obvious—a thorough knowledge of subject matter, an acquaintance with the latest scientific information and methods as well as techniques for their application. As patients have greater access to publications it becomes increasingly important for us to be able to interpret to them the newer developments in antepartum care. We are constantly being confronted with a greater challenge to

prove the worth of our services by showing parents that we can be of real value in helping them with their planning.

Not only is there importance in the material we present, but also in the way in which it is presented. Our methods of sharing information with the patient must be watched carefully for necessary adaptations. For only with a mind open for change and progress will our skill constantly increase.

Whether working in the large urban center with many facilities or in the area sparsely settled and with difficult transportation, we have common problems. These problems must be recognized, analyzed, and interpreted in the light of the local situations. When the findings show that we need to increase our efficiency, let us be the ones to chart the new course, through an evaluation of our activities. This includes a weighing of the methods which have produced good results as well as those which have failed in achieving their goal.

Presented before the Nursing Section, The First American Congress on Obstetrics and Gynecology, Cleveland, Ohio, September 12, 1939.

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² Chicago Lying-in Hospital and Dispensary, Admitting Department. Unpublished records.

³ Wiehl, Dorothy G., and Berry, Katharine. "Maternal Health and Supervision in a Rural Area." *Milbank Memorial Fund Quarterly*, April 1939, p. 177.

⁴ Metropolitan Life Insurance Company, *op. cit.*, p. 6.

⁵ Wiehl, Dorothy G., and Berry, Katharine, *op. cit.*, 183.

⁶ *Ibid.*

⁷ *Ibid.*, p. 184.

⁸ Goddard, Jennie C., and Palmer, Carroll E. "Maternal Services in Michigan with Special Reference to Economic Status." *U. S. Public Health Reports*, May 19, 1939, p. 835.

A GUIDE TO THE SCHOOL NURSE

Every school nurse is interested in children with functional scoliosis. Page 6.

Suggestions for help which the school nurse can secure from her nursing supervisor are given on page 48.

Diabetic children present a very special problem. Page 3.

A college health program which includes use of the training school for the health education of student teachers is described on page 17.

The Nurse in an Eye Health Program

By PEARL McIVER, R.N.

A discussion of the relationship between the nurse in the sight conservation program and the official health agency

TWO FUNDAMENTAL motives have stimulated the organization of programs which are designed to prevent blindness. The earliest motive was the humanitarian one. A blind child, who can never enjoy the wonders of this world through the sense of sight, arouses sympathy in the most calloused individual. Since voluntary agencies were the first to develop extensive programs for the prevention of blindness, and since these agencies depended to a large extent upon private donations for the support of their programs, it was not surprising that the humanitarian motive was the dominating factor during the early years.

However, the economic factor soon became apparent. Educators pointed out the extreme difference between the cost of educating a blind child and that of educating a child who had normal vision. Welfare departments realized the terrific cost of pensions or other means of support for those who were public charges because of blindness. This second factor, the economic aspect of blindness, was the force which motivated state and local appropriating bodies to do something about its prevention.

About twenty years ago, almost one third of the blind pensioners in the State of Missouri were blind because of trachoma, and up to that time the state legislature had made no appropriations to prevent or cure the disease. The humanitarian motive had not been sufficient to secure appropriations for trachoma prevention work, but a clear presentation of the economic loss and an

estimate of the saving in blind pensions was sufficient to secure legislative support for a trachoma eradication program.

Interest in the economic aspects of the prevention of blindness resulted in the establishment of state commissions for the blind, and special appropriations were made for the prevention and control of such diseases as ophthalmia neonatorum and trachoma.

Surgeon C. E. Rice, U. S. Public Health Service consultant on blindness to the Social Security Board, says in discussing blindness as a public health problem in the United States:¹

One half of the blindness in children is the result of congenital and hereditary defects and diseases. Syphilis is a problem here but by no means the whole story. This phase of prevention is a challenging one and is practically an untouched field.

One half of the blindness coming on in late youth and adult life can be charged to four factors (1) syphilis, prenatal or acquired (2) cataracts (3) glaucoma and (4) trauma. Syphilis does most of its work here by producing atrophy of the optic nerve. The cause of cataracts and glaucoma is unknown. Most cataracts are amenable to surgical procedures. Many individuals who have glaucoma are not seen early enough, or if seen early, the general practitioner does not recognize the condition. If the condition is recognized when seen early, the patient does not always realize the seriousness of the condition, so fails to remain under observation. Glaucoma, therefore, is largely a problem in education of the general practitioner as well as education of the patient. Trauma, also, industrial and nonindustrial, as a cause of blindness, is largely an educational matter.

From Doctor Rice's statement it is

¹ Bean, Helen. "Public Health Nursing." *The Health Officer*, March 1938, p. 589.

quite evident that the prevention of blindness, which involves syphilis control, antepartum care, accident prevention, and health education, is a problem which should be interwoven with the entire health program. In the analysis of "Nursing Functions Which Contribute to the Promotion of Eye Health," which was prepared under the guidance of the Advisory Nursing Committee of the National Society for the Prevention of Blindness, this same conception of the interdependence of eye health and general health appears:

Protection and promotion of eye health are a function of nursing. Indirectly all nursing functions which contribute to general health also assist in maintaining the health of the eyes and in saving sight. However, the prevention of ophthalmological conditions lies largely in recognition of the interrelation of eye health and general health and in the development of health, educational, industrial, and social programs which give due consideration to the maintenance of eye health. Nursing functions in such programs contribute both directly and indirectly to the health of the eyes.²

It would appear that the interrelationship and the interdependence of programs designed to prevent blindness and programs which are concerned with general public health are inevitable. It naturally follows that the agency which is responsible for the whole public health program of a state or area should be the coordinator of blindness prevention work.

A plan emphasizing the place that should be occupied by the state health department and the relationship with other blindness prevention agencies has been outlined by the Committee on Conservation of Vision of the State and Provincial Health Authorities of North America. This committee recommended:

A sight conservation service established in the state health department to serve as a

stimulator and coordinator of all activities relating to the prevention of blindness and conservation of vision. The person in charge of this service will be directly responsible to the executive officer of the state department of health. In addition to promoting a distinct program in eye hygiene, it will be the function of this service to encourage and coordinate the several activities of other agencies, departments, and divisions which may have responsibility in this field, and to bring about a completely integrated state program.

Such an arrangement will necessitate a close interdepartmental relationship; it will lead to a united front; and it will serve to focus all educational, medical, and social services for prevention of blindness and restoration of vision.

A service as contemplated in this outline will be organized on the basis of a functional rather than a categorical approach. On this basis it will operate largely through existing state and local agencies, bureaus, and divisions rather than assume responsibility itself for setting up machinery to actually carry a complete program. Accordingly, it will be essential to develop cooperative relations with the following groups: educational, medical and nursing, welfare, industrial, vocational rehabilitation, volunteer, and lay organizations, and state commissions.³

PUBLIC HEALTH NURSING FUNCTIONS

Public health leaders have agreed that public health nursing is most effective when it is organized as a generalized service and one nurse renders all of the public health nursing service needed by the families of a certain area. If we accept that statement (and most of us do), is there a place for a special worker in prevention of blindness to render a direct community service? In other words, should a public health nurse who is concerned only with blindness prevention visit families for the purpose of rendering direct service to those families? The answer seems quite clear. It does not appear that there is need for a special worker to render this type of service.

² National Society for the Prevention of Blindness. *Nursing Functions Which Contribute to the Promotion of Eye Health*. 50 West 50 Street, New York, N.Y., 1939.

³ Proceedings of Fifty-third Annual Meeting of the Conference of State and Provincial Health Authorities of North America, held at Washington, D.C., April 9, 11, 1938, pp. 109 and 112.

We should rather concentrate our efforts and resources on securing enough qualified general public health nurses so that each community nurse will have the time and the ability to promote sight conservation programs and to render whatever nursing service is needed in the prevention of blindness.

However, the proponents of a specialized service may say that the general public health nurses know very little about eye hygiene and that they are apparently not interested in promoting this phase of the health program. Such a statement may be true and most of us are in hearty agreement with the specialist in the prevention of blindness who urges more and better training in this field for all public health nurses.

NEED FOR SPECIAL CONSULTANTS

The answer to this problem may be found in the employment of nursing consultants who are well qualified in the general field of public health nursing, and who in addition have had special preparation in the prevention of blindness and the conservation of sight. These consultants might be employed by the state health department, by the state commission for the blind, or by a non-official state agency which is concerned with this specialty. If the consultant is employed by the state health department, she may be one of the regular general public health nursing consultants who has had special preparation in eye hygiene. Under this plan, she may serve as general consultant to the nurses of her own district and as special consultant on eye hygiene to the nurses in the other districts. If she is employed by an agency for the prevention of blindness, her qualifications should be the same; but she will naturally serve only as a special consultant, and her services to the local nurses will be most effective if arranged through the general consultant employed by the state health department.

There are approximately fifteen public health nurses in the United States who are employed by state commissions for the blind. Five of these fifteen are employed in one state, and the majority of the others are employed in the states of the northeastern area. Very few of these nurses could qualify as public health nursing supervisors or consultants according to the standards recommended by the Conference of State and Territorial Health Officers. Most of these nurses are engaged in promotional work or in rendering direct service to individuals on an itinerant basis. Rarely is there any well defined plan by which the work of the nurses employed by the commissions for the blind is correlated with the work of other local or state public health nurses.*

In conclusion, it would appear that:

1. An effective program for the prevention of blindness is so dependent upon the other health and welfare services of a state or local community that it must be developed as an integral part of the entire public health program.
2. The recommendation with regard to a coordinated program for sight conservation which was adopted by the State and Provincial Health Authorities of North America at their fifty-third annual meeting appears to be a logical solution to this problem.
3. The public health nursing services needed by a family are most effective when these services are rendered by one nurse on a family basis. Therefore, it is believed that services which pertain to the prevention of blindness should be included as a regular part of the program of every generalized public health nurse.
4. Inasmuch as many general public health nurses have a limited knowledge of eye hygiene, in-service training programs which emphasize this specialty should be developed. Such programs

*Information obtained from the National Society for the Prevention of Blindness, 50 West 50 Street, New York, N.Y.

should be planned and directed by one of the general supervisors of the state health department who has had special preparation in eye hygiene, or by a qualified nursing consultant from the blindness prevention agency. If the special consultant is employed, the educational program should be worked out in cooperation with the general nursing consultants of the state health department.

5. The economic costs of blindness, as

well as the physical and emotional suffering which accompany an individual's loss of sight, are so great that the prevention of blindness and the conservation of vision should become a recognized responsibility of all public health nurses, no matter what may be their special fields of activity.

Presented before the annual meeting of the National Society for the Prevention of Blindness, New York, N.Y., October 26, 1939.

The A.P.H.A. Meeting in Pittsburgh

THE ANNUAL MEETING of the American Public Health Association was held in Pittsburgh, Pennsylvania, October 17-20. There were 2535 people registered, and approximately 240 papers and reports were presented. The meetings were well attended.

Back of these three sentences lies a year of careful, thoughtful program-planning on the part of the A.P.H.A. Governing Council, committees, and sections; a week of incessant, fatiguing demands on the A.P.H.A. staff as they struggled to keep the convention guests, exhibitors, and speakers comfortable and happy; and of course long hours of hard work voluntarily given by the speakers on the preparation of their papers—many of which gave us the results of original research, and which offered an unusual spread of fresh ideas.

Is this all that a convention is? To hear the good papers, sleep through the dull ones, and watch the clock for the next appointment—be it business or pleasure? Only the most hard-boiled conventioner would deny that there are a hundred intangibles which form the real heart and soul of a convention: The

A.P.H.A. meeting in Pittsburgh radiated these intangibles to a high degree. The general sessions offered the best in public health leadership; the sections, the cream of studies and research; the joint sessions, a genuine spirit of partnership.

More than one old hand at national meetings remarked that *this* program had punch. "We are getting somewhere. Did you hear the paper on . . .?" Or as the young lady who could not possibly have attended many conventions in her short life remarked in the elevator in a burst of self-expression. "My dear, they are not dodoes after all! I got more out of that paper than in all my college course last winter! Am I glad I came!"

For those who did not share in any of the intangibles in Pittsburgh, we suggest reading the following papers as soon as they appear in the *American Journal of Public Health*:

December 1939 issue:

"Health for Three-Thirds of the Nation," by Edward S. Godfrey, Jr., M.D.

"Some Essentials in Training for Public Health," by Alan Gregg, M.D.

"The Trained Worker Goes to Work," by W. P. Shepard, M.D.

Scheduled for future issues:

"Changes in Public Health Nursing Functions Implied in the Recent Advances in Medicine," by Iago Galdston, M.D.

"Coördination of Educational Programs for All Health Workers," by Reba F. Harris.

"Supervision of Public Health Nurses—From the Point of View of the Rural Agency," by Anna Heisler.

The officers elected for the coming year are:

President—Edward S. Godfrey, Jr., M.D., Albany, N. Y.

President-elect—W. S. Leathers, M.D., Nashville, Tenn.

First vice-president—Elizabeth L. Smellie, Ottawa, Canada

Second vice-president—Domingo F. Ramos, M.D., Havana, Cuba

Third vice-president—Wilton L. Halverson, M.D., Pasadena, Calif.

Treasurer—Louis I. Dublin, Ph.D., New York, N. Y.

Chairman of executive board—Abel Wolman, Dr. Eng., Baltimore, Md.

Executive secretary—Reginald M. Atwater, M.D., New York, N. Y.

The new members of the Governing Council are:

J. N. Baker, M.D., Montgomery, Ala.
Karl F. Meyer, Ph.D., M.D., San Francisco, Calif.

Harry S. Mustard, M.D., New York, N. Y.

George H. Ramsey, M.D., White Plains, N. Y.

W. S. Rankin, M.D., Charlotte, N. C.

Robert H. Riley, M.D., Baltimore, Md.

L. R. Thompson, M.D., Washington, D. C.

W. Frank Walker, Dr.P.H., New York, N. Y.

Robert E. Wodehouse, M.D., Dr.P.H., Ottawa, Canada

Hans Zinsser, M.D., Sc.D., Boston, Mass.

The officers of the Public Health Nursing Section are:

Chairman—Marion W. Sheahan, Albany, N. Y.

Vice-chairman—Laura A. Draper, Minneapolis, Minn.

Secretary—Leah M. Blaisdell, New York, N. Y.

The next convention will be held in Detroit, Michigan, in the fall of 1940. We advise you candidly not to miss it.

D. D.

NURSE PLACEMENT SERVICE



announces the following placements from among appointments made in

the various fields of public health nursing. As is our custom, consent to publish these has been secured in each case from both nurse and employer.

*Lydia Arndt, Director, Visiting Nurse Association, Dubuque, Iowa

*Ina Reynolds, Instructor in Public Health Nursing, Union Memorial Hospital School of Nursing, Baltimore, Md.

*Dorothy F. Johnston, Public Health Nurse, District Nursing Association of Northern Westchester County, Mt. Kisco, N.Y.

Ethel Hoffa, County Nurse, Lyon County Nursing Service, Rock Rapids, Iowa

Mrs. Ardys Fiske, County Nurse, Louisville Tuberculosis Association, Louisville, Ky.

Evelyn Leonard, Junior Nurse, Fairmont Red Cross Chapter, Fairmont, W.Va.

Elizabeth Moroney, Staff Nurse, Training Unit at Harrisburg, Ill., under State Department of Health.

ASSISTED PLACEMENTS

*Marcetta Horne, Supervising Nurse, Houghton-Keweenaw District Health Department, Houghton, Mich.

*Helen Binz, Staff Nurse, Cattaraugus County Department of Health, Olean, N.Y.

There continues to be a definite demand for well prepared people for supervisory positions, especially in the specialized services. Shortly after the first of the year, employers in the school nursing field will be interested in nurses to fill vacancies in their school systems next fall.

*Member of the National Organization for Public Health Nursing.

Income in Nonofficial Agencies---1938

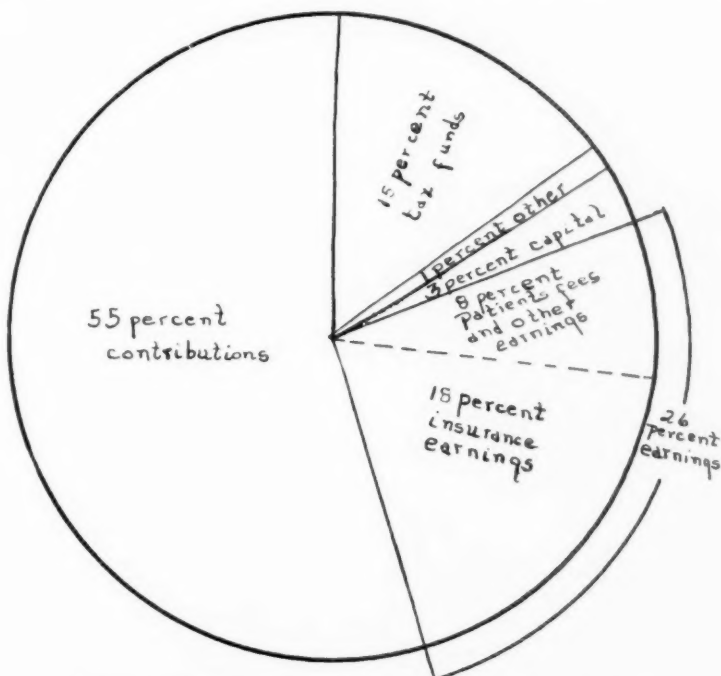
By LOUISE HOPWOOD

What are the sources of income of voluntary public health nursing agencies? Do they have any relation to the geographical location and the size of the agency?

IT IS ALWAYS a matter of concern to the National Organization for Public Health Nursing to trace the changes year by year in the amount of support which nonofficial public health nursing agencies are receiving from the various accepted sources of income. This year the income review has been more

thorough than usual and the results as analyzed by the statistical department are offered here with some interpretative comments for your consideration.

Of the 225 nonofficial agencies returning the questionnaire, 216 of the answers were in a statistically usable form. In 1937* the study included 182 agencies.



Median* percent income in 216 public health nursing organizations

* Reid, Mabel. "What's Done We Partly May Compute." PUBLIC HEALTH NURSING, January 1939, p. 37.

** The median in a series is the middle item; the number of items below the median is the same as the number of items above it.

TABLE I
PERCENT OF TOTAL INCOME BY TYPE OF INCOME (NONOFFICIAL AGENCIES)

Type of income	Percent of total income	
	1938	1937
Total income	100.0	100.0
Tax funds	8.0	8.5
Capital and endowment	7.0	7.9
Contributions	56.2	53.8
Earnings	27.9	29.1
Other	0.9	0.7

Thus the samples being studied increased by 34.

The questionnaire asked that income be reported under five main headings as follows:

1. Contributions: All contributions from sources such as the American Red Cross, Christmas seal sale, and community chest; membership dues; and income from entertainments or fairs under the auspices of board members, women's clubs, and other groups.
2. Earnings: All fees earned by the organization. This does not include money from tax sources.
3. Tax funds: All income from tax funds appropriated by the city, county, or state as an outright grant for nursing work or paid for on a visit basis.
4. Capital and endowment: All interest on endowment and invested funds, bequests, and rent from property owned but not used by the agency.
5. Other: All refunds, receipts from sales and rental of supplies, and loans from banks.

The percentage of total income received from each source of income is given in Table I.

The differences in the percentages for the two years show that income from contributions increased while the money from tax funds, capital and endowment, and earnings decreased. The above percentages are based on total income for all organizations. It is worth noting that

only 66 agencies reported all five types of income.

This question is often asked: What percent of income may an agency hope for from each source? Table II shows the median percent of income of each type for those agencies that received such money.

Every one of the 216 agencies received money from contributions. Second in frequency is earnings, only 8 not reporting income of this type. Tax funds are shown in 65.3 percent of the agencies, capital funds in 65.7 percent, and other types of income in 55.6 percent. When the 141 agencies receiving tax money were studied, the median agency showed that 15.7 percent of its funds came from this source. This is almost double the proportion shown when percentage distribution of total income was calculated. The other four types of income show less deviation between the two methods of calculation, with the exception of capital funds. In Table I, 7 percent of all the income is from capital funds, but in Table II it is shown that the median organization received only 2.8 percent of its income from such sources.

Geographical location and number of nurses employed affect the findings in studies of public health nursing; therefore, the five types of income were studied according to the location and size of the agencies. These geographical divisions (see Table III) are the same as those used in the article "Going Forth," published in the November 1939 issue of

TABLE II
MEDIAN PERCENT OF INCOME AND NUMBER OF AGENCIES REPORTING THIS TYPE
OF INCOME, BY TYPE OF INCOME

Type of income	Median percent of income	Number of agencies		Percent of agencies	
		Reporting this type of income	Not reporting this type of income	Reporting this type of income	Not reporting this type of income
Contributions	55.0	216	—	100.0	—
Earnings	26.2	208	8	96.3	3.7
Tax funds	15.7	141	75	65.3	34.7
Capital and endowment	2.8	142	74	65.7	34.3
Other	0.8	120	96	55.6	44.4

PUBLIC HEALTH NURSING. (See page 624.) Of the 216 agencies, 67 are in New England, 67 in the Middle Atlantic area, 14 in the South, 54 in the Middle West, 13 in the Far West, and 1 in Hawaii.

So far as the number of nurses employed is concerned, 5 agencies employed 100 and over; 8 agencies employed 50-99 nurses; 13 agencies employed 25-49 nurses; 25 agencies employed 15-24 nurses; 27 agencies employed 10-14 nurses; 56 agencies employed 5-9 nurses; 58 employed 2-4 nurses; and in 24 agencies only 1 nurse was employed.

Our sample of 216 agencies represents the actual geographical distribution of nonofficial agencies only fairly well. However, every section of the country is represented by at least 10 agencies. So far as size of agency is concerned,

only 11 percent of our sample consists of one-nurse agencies whereas in the country as a whole this size of agency is more common.

CONTRIBUTIONS

Because all agencies reported money from contributions and because this type of income accounted for more than half of the total income reported by the 216 agencies we are considering it first.

This is the only source of income which was received by every nonofficial agency. The amount of contributions varies according to geographical location and size of agency. The median agency in our sample shows that 55 percent of its income was from contributions.

In the South and the Far West indications are that a larger proportion of income was from contributions, although

TABLE III
MEDIAN PERCENT OF TYPE OF INCOME BY GEOGRAPHICAL LOCATION

Geographical location	Total	Contri- butions	Earnings	Tax funds	Capital and endowment	Other
United States	100.5	55.0	26.2	15.7	2.8	0.8
New England	96.3	43.2	29.1	20.3	3.7	
Middle Atlantic	102.1	53.7	29.7	16.2	2.5	
South	106.2	70.0	21.2	12.5	2.5	
Middle West	103.1	67.1	22.2	10.8	3.0	
Far West	109.8	70.8	20.0	15.0	4.0	
Other	100.0	96.3*	3.7*			

*Actual percent rather than median percent, as only one agency reported.

TABLE IV
MEDIAN PERCENT OF TYPE OF INCOME BY SIZE OF AGENCY

Number of nurses employed	Total	Contributions	Earnings	Tax funds	Capital and endowment	Other
Total	100.5	55.0	26.2	15.7	2.8	0.8
100 and more	95.0	42.5	37.5	7.5	7.5	
50-99	96.0	62.5	22.5	7.5	3.5	
25-49	97.3	58.8	31.2	3.8	3.5	
15-24	100.5	49.4	32.0	15.1	4.0	
10-14	94.7	51.2	28.6	12.5	2.4	
5-9	99.5	52.9	27.2	16.1	3.3	
2-4	102.8	60.0	23.2	17.5	2.1	
1	106.0	55.0	20.0	30.0	1.0	

the number of agencies is rather small for these sections. In New England the proportion from contributions is noticeably below the median in the 216 agencies. The largest contributions on the whole were made by community chests. A total of 152 agencies received chest contributions, and 104 of these agencies received 90 percent or over of their total contributions from this source. The population of the community served affects the amount of the chest contributions because small places do not have community chests and depend upon contributions from membership dues, individuals, drives, or income from benefits, et cetera. There are 64 agencies that did not receive contributions from community chests. Of these 42 are small agencies employing 4 or less nurses in New England and the Middle Atlantic areas. The size of the community served directly affects the contributions from community chests.

EARNINGS

The earnings of an organization account for a little more than one fourth of its income when based on the median percent. Insurance earnings accounted for 77 percent of the total earnings of the 208 organizations reporting this source of income. When stated as a median percentage, 18 percent of the total income was received from insurance

earnings. The other earnings were derived mostly from patients' fees.

Earnings are affected by geographical location. The New England and Middle Atlantic sections are the only ones that received higher than the median percent of income from earnings. The percent of total earnings which is derived from insurance earnings shows a different picture in regard to geographical location. The South and Middle West received 86 percent and 83 percent respectively of their total earnings from insurance companies. A total of 22 organizations received 50 percent of their total income from all types of earnings, and of these, 7 organizations received over 50 percent of their total income from insurance earnings.

The size of the agency only slightly affects the proportion of income from earnings. This figure is highest in the largest organizations and least in the smallest. Agencies which do not have insurance contracts show a small percentage of income from earnings. This type of income is not as much affected by the size or location of the agency as it is by the type of program rendered by the organization. Agencies with extended health supervision programs cannot show a proportion of earned income equal to agencies with less health supervision and more emphasis on bedside nursing.

TAX FUNDS

Income from tax funds is the third highest source of support. In 1938 the median organization received 15.7 percent of its income from taxes. Of the total money reported by the 216 organizations in 1938, 8 percent came from taxes. Last year, 8.5 percent of the income of the 182 agencies came from taxes. This variation is not significant.

The amount of tax funds received varies according to geographical location and the size of the agency. The New England and Middle Atlantic areas received higher than the median percent of income from tax funds and the other sections received less than the median percent. So far as the size of agency is concerned, only those agencies employing less than 10 nurses received more than the median percent of income from tax funds. These two factors—geographical location and size of agency—have a relationship in that 68 percent of the small nonofficial agencies are in the New England and Middle Atlantic sections of the country.

Tax funds are received from the three sources: city or township, county, and state. When the material was analyzed as to the source of the tax funds it was found that 81.7 percent of all tax funds was received from the city or township.

The purpose for which tax funds were granted covered the whole range of public health nursing activities. In small organizations it was most often given for a general program, while in large organizations it was more often given for a specialized service. The range of income from tax funds is as follows: 75 agencies received no income from this source; 33 agencies received more than 25 percent of their income from tax funds. Of these 33 agencies, only 2 employed more than 15 nurses and 31 employed less than 15 nurses.

The proportion of tax funds varies according to the size of the organization because in small agencies that serve small

communities there is less likely to be an official nursing service and the median percent of income from tax funds is higher, while in large organizations in metropolitan areas there is a separate official staff.

CAPITAL FUNDS AND ENDOWMENT

Capital funds account for a small proportion of income in most organizations. There are a few notable exceptions to this statement. The median percent among the agencies reporting such income was 2.8. In 27 organizations, however, more than 10 percent of the income was from capital funds. On the other hand, 74 organizations reported nothing at all from capital funds. The income from this source is more affected by the size of agency than by the geographical location. The organizations employing 100 or more nurses received the highest median percent of income from this source. These agencies in all instances were the older, well established agencies in the metropolitan locations. The one-nurse agency received the lowest median percent of income from capital funds. Geographical location did not have a noticeable effect on this form of income. It is of some interest to note however that the Far West received the highest median percent of income from this source, but only 6 agencies are represented.

OTHER INCOME

The income from other sources is in the majority of cases from refunds; selling of supplies; renting of maternity packs, wheel chairs, and other supplies; and in some rare instances, from loans. In most instances where the "other income" has exceeded 5 percent, money has been borrowed to meet a deficit. There were 96 agencies, or 44.4 percent, that did not receive income from this source. Of the 120 agencies receiving this type of income, 73 agencies received less than 1 percent. This ma-

terial was not analyzed by geographical location and size of agency because of the small percent of income from this source.

INCOME IN COMBINED AGENCIES*

The median percentages of income in combined agencies present an entirely different picture than that shown by the nonofficial agencies. Of the 17 combined agencies, a total of 14 made their reports in a statistically usable form. The median percentages of income as reported are as follows:

Contributions	40.0 percent
Earnings	12.5 percent
Tax funds	45.0 percent
Capital endowment	3.5 percent
Other	3.0 percent

It is seen that tax funds in the combined agencies represent almost three

*A combined agency is one in which non-official and official agencies are working together so closely that it is not possible to classify it as either.

times the proportion found in the group of nonofficial agencies. On the other hand, the median percent of income from contributions is much less, this figure for the nonofficial agencies being 55 percent. Of the 11 combined agencies receiving community chest contributions, 7 agencies received 90 percent or more of their total contributions from this source.

The income from earnings is lower also among these combined agencies. It is interesting to see that 77 percent of the total income from earnings—the same figure that was reported for nonofficial agencies—was derived from insurance earnings.

The difference between the nonofficial agencies and the combined agencies in the median percentages of income derived from the 5 main types of income might be accounted for by the generalized aspect of the program in the combined agency and in the joining together of all forces for a communitywide public health nursing service.

THE CHANGING PICTURE

The following comments on the findings of this study are presented by the general director of the N.O.P.H.N.:

In general, what do these findings mean to the present and future position of the nonofficial agency? Assuming that the N.O.P.H.N. sampling is indicative of the situation in other public health nursing agencies, we question at once: Why have earnings decreased at a time when agencies are endeavoring to offer nursing service to part- and full-pay patients and there is earnest effort to respond to every community need? Obviously there may be a shift because the group of patients who were formerly able to pay a little are now on relief and the cost of their care is met through taxes or gifts. Obviously, also, there may be greater hospitalization of the full-pay clientele. Also, there are

actually in many communities fewer insured patients, and moreover the insurance companies are setting some limitations to service—although it would not seem that the effect of such limitations would have been felt in 1938.

Contributions are increased 2 percent in 1938 over 1937. This is good news. Is there a swing toward more support from contributors or is this because we are doing a better interpretative job? Or have chest campaigns been more successful? Perhaps all three.

Sixty-five percent of these nonofficial agencies received some form of tax support. It is a little puzzling to know why the tax income median in the Middle West is low. But equally surprising is the finding that the Far West agencies have a median of 70.8 percent from contributions, while in New England where the nonofficial agency is prevalent, we

find 43.2 percent. Or is this the answer: The nonofficial agency in the Far West thrives on the fact that it is less common and therefore unique. The earnings of Far West agencies are low, which perhaps indicates that the pressure to develop part- and full-pay service is not felt so keenly there; but it would appear from these figures that income from tax funds is not bringing sufficient support to warrant neglecting service to paying patients.

This is the first year that we have analyzed income sources by geographical location. We should like our readers' comments.

We would expect to find—as we do—that large agencies have nest eggs in the form of endowments, the interest from which is used for current expenses. During the depression years the N.O.P.H.N. questioned the wisdom of conserving endowments (that is, those which are not legally "frozen" into inaccessibility) at the cost of curtailing much needed nursing service or of cutting nurses' salaries to the point where good quality of care was threatened. There is still, we believe, a grave question as to the ethics of building and hoarding an endowment so large that more than 50 percent of current income is derived from invested funds. Contributors urged to give in order to meet the current dire needs of the service may also question the jus-

tification of such an appeal. Each agency should decide where the line shall be drawn between maintaining a reserve for emergencies and a judicious use of endowed funds for the promotion of growth and the immediate needs of the service.

One of the bright sides in the picture is, we believe, that out of 216 agencies 22 were more than half self-supporting. Even subtracting the seven which were deriving much of their support from insurance payments, we have left 15 agencies working toward a more stable position in their communities through direct payment from patients.

The fourteen combined services give us a new picture of support. Naturally, their share of income from tax funds is large, and the contributions low. Is it also significant that the amount of earned income is less? We have questioned before whether there is less paid service in a combined official and non-official agency than in a nonofficial agency. In these fourteen, there would seem to be less, but whether such a decrease was due to the policy of the agency, the approach of the staff, the type of patient served, or some other cause, we do not know.

The N.O.P.H.N. will welcome comments on this material.

DOROTHY DEMING, R.N.

*General Director, National Organization
for Public Health Nursing*

THE AMERICAN JOURNAL OF NURSING FOR JANUARY

Colonic Surgery.....	Joseph M. Miller, M.D., and Charles W. Mayo, M.D.
The Harmon Association Grows.....	Mary Brady
What the Staff Nurses Wanted.....	Anna M. Taylor, R.N.
Organizing a Community Nursing Service.....	Marion Wetzel, R.N., and Beatrice Tremper, R.N.
Our South American Colleagues.....	Bertha L. Pullen, R.N.
Toward Educating 130 Million People.....	Ernestine Wiedenbach, R.N.
The Psychiatric Nurse.....	
Maternity Care.....	Verda Hickcox, R.N.
A State of War Exists!.....	Jane Foster, R.N.

Baby's corner
is ready well
ahead of time



Mother rests
while the baby
has a sunbath

THE Maternity Center Association has just made available an attractive set of 31 picture charts, which illustrate safe maternity care from the time the expectant mother selects her doctor before the third month of pregnancy through the check-up three months after the baby comes. The charts are designed for use on the walls of maternity clinics where they teach the patient important points in maternal care as she waits for her appointment with the doctor and nurse. They can also be used as illustrative teaching materials for classes for expectant mothers or fathers. The pictures when mounted on heavy cardboard may be used as an exhibit at a county fair or meeting, or as a window display.

This set may be obtained from the Maternity Center Association, 654 Madison Avenue, New York, for \$1.50.



Doctors know better than gossips

Mother learns something each day



Supplies for home delivery are prepared and sterilized

The Supervision of School Nursing

By MELLIE F. PALMER, R.N.

A practical discussion of problems involved in the supervision of school nursing in a generalized public health nursing program

THE SUPERVISION of school nursing involves certain specific problems in addition to those which belong to all supervision. Several of these problems will be analyzed here, together with some suggestions for improving the service—particularly when it is conducted as a part of a generalized public health nursing program.

The fundamental philosophy underlying supervision will not be discussed in this article. It is assumed that the concepts of respect for personality and the right of self-direction and growth—all for the ultimate improvement of service—are inherent in supervision regardless of the type of undertaking which is supervised. It is also assumed that the same basic principles are a part of all supervision. It should:*

- Provide democratic leadership.
- Stimulate creativeness.
- Bring about improvement of service through the growth of the nurse.
- Be kindly and sympathetic.
- Be approached objectively.
- Be a definitely organized program.
- Be a cooperative undertaking.
- Include both teaching and administrative functions.

ADMINISTRATIVE PROBLEMS

A foremost problem in school nursing is that of administrative organization. While the public health nurse always has a responsibility to diverse groups, school nursing conducted on a generalized basis

very definitely places the nurse in the position of serving several masters whose interests and methods of procedure may conflict. Moreover, there is no standard and generally accepted school health program with definite policies to guide the nurse's conduct of her part of it. Therefore it is essential that lines of authority and interrelationships be well understood by everyone concerned.

It is not sufficient that the executives agree to work together harmoniously so that the work of the staff may be effective. Supervisory assistance is needed to bring about an efficient as well as a harmonious relationship. Obviously the person rendering such assistance must thoroughly understand both the school organization and the public health organization which employs the nurse as a family health worker. It is difficult for the staff nurse to have a comprehensive view of the whole, and it is equally difficult for the executives of both organizations to have an intimate knowledge of those things which will be most helpful to the staff nurse. Furthermore it takes time and thought to develop detailed plans. The supervisor can study the entire situation, and, working with the executives of the school, the health organization, and the staff nurse, she can evolve a plan which will permit the nurse to work efficiently and without confusion. The plan should be written and should include definite and clearly stated objectives, policies governing relationships, and procedures as they are carried out by the nurse. These may

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then be distributed to the persons concerned.

An example of the use of supervisory assistance in this way is a bulletin on interdepartmental relationships which was prepared for school nurses and members of a physical education department, by the supervisors of the two departments. The bulletin included statements of the responsibilities of members of both groups under various circumstances, described under headings such as "conduct of health examinations," "care of athlete's foot," and "first aid and care of emergencies," and covering various activities where clarification of responsibility was needed. During the preparation of the bulletin the supervisors held individual and group conferences with members of their respective staffs, for the discussion of these problems. Following the completion of the plan it was necessary for the supervisors to interpret it as new situations arose, and as new members came to their staffs.

A COUNCIL TO INTEGRATE PROGRAM

Another organization problem is the establishment of channels which will make the staff nurse's school work effective with the least possible expenditure of time and effort. The effectiveness of her work depends upon the integration of school health activities with the rest of the school program and with other community activities. Such coordination involves activities and understanding on the part of school personnel, parents, medical and dental groups, and other social and health agencies of the community. The nurse as the coordinator of health knowledge and health behavior among these individuals and groups needs assistance in securing a local health council or committee to facilitate this integration. Supervisory assistance may be needed to convince the nurse that such a council can be helpful. She may need assistance in convincing the school executive that a council is a

help and not a hindrance; in developing the confidence necessary for working with a council; and in evolving methods of keeping it active and interested once it is organized. As an illustration, consider this situation.

A school principal had not been able to see the necessity for a health council. The nurse in his estimation was conducting a satisfactory health program. He already had some inactive committees and did not want another one. While he had been approached several times about the matter he had never been convinced and so it was dropped. Then a measles epidemic broke out in the school. The nurse, with the help of her supervisor, used this opportunity to demonstrate the use which could be made of a council. There was great consternation in the school because of the wrecked attendance. The parents were upset because the epidemic had occurred in spite of the school nurse and the school doctor. There seemed to be misunderstanding in regard to the exclusions from school and the regulations of the health department. The nurse suggested to the principal that he call a conference of some of the people who might assist in bringing about a better understanding of the situation. He called in the school physician, the health officer, the nurse, the chairman of the health committee of the parent-teacher association, and representative teachers. The staff nurse was allowed to ask her supervisor to come to the conference.

At the first conference the health officer interpreted the regulations. The school physician, who was a practicing pediatrician, explained that measles were very communicable. He told how the disease seemed to spread. He described something of the complications and the care. And he emphasized the importance of protecting the young child. The nurse described her part in the program of control—that of visiting the homes where medical and

nursing care was most needed and where there were preschool children. After some discussion the conferees planned an educational program for the school and community. The direct outcomes were a series of letters to parents, the inclusion of information about measles on a commercial leaflet which was distributed from door to door, and four discussions of communicable disease by parent study groups.

HELP GIVEN BY SUPERVISOR

The supervisor assisted the nurse by obtaining interesting and pertinent information about measles, by helping her to select leaders for the parent study groups, and by assisting her in the preparation of thought-provoking reports for the school conferences. As a result of three conferences the principal observed that there were possibilities in this sort of group and he therefore asked the nurse and her supervisor for advice in regard to the formation of a permanent health council. He asked the supervisor to attend the meeting at which the council was to be organized and to tell the group about the organization of other health councils.

Thus, when the council was organized it profited from the experience of others. It was not so large as to be unwieldy. It was representative of people essential in the functioning of a school health program. Its chairman was selected by the group. It planned to draw up objectives and regulations for its work. Some immediate and worth-while problems were presented for it to consider.

The supervisor assisted in some of the following ways. She made it possible for members of this council to visit other functioning school health councils. She attended the meetings occasionally, and when called upon she offered stimulating comments. She helped the nurse become more keenly aware of school needs which the council might assist in meeting. Some of her suggestions resulted in the

appointment of a subcommittee for the study of health instruction as it relates to health service; in the study by the council of remedial medical and dental resources for those children who were not having defects corrected; in the study of school health behavior by committee members; and in the appointment of a student committee to plan improved management of the lunch period at school. The supervisor gave the nurse opportunities at staff meetings to practice presenting reports in an interesting manner. She prepared appropriate local statistical data for the nurse to present in visual and graphic form to the council. She made it possible for the nurses to compare ways of presenting materials to their respective councils and to discuss the part the nurse took in the council. She helped the nurse take advantage of the opportunity for using a problem to demonstrate to the principal the function of a council. She was alert to other problems which she and the nurse interpreted to the principal, and which prompted the formation of a council. The nurse found her work multiplied in effectiveness by the members of this group and by their respective circles of influence.

PLANNING THE NURSE'S SCHEDULE

A second real problem is the management of the nurse's time. The nurse as a family health worker is responsible for the supervision of the health of all members of the family including the school child. She is responsible for this supervision both when school is in session and when it is not. As a family health worker she works either with individuals or with voluntary groups who may meet for discussion in classes or clinics. As a school nurse she works with a highly organized group, which is congregated in a central place and where the schedule runs like clockwork. This group has definite obligations to the community, which are tangibly indi-

cated by attendance, scholastic achievement, and progress in school—of which the nurse must be understanding and sympathetic.

Although she may recognize the importance of spending the major part of her time in the homes, with parents, working with preschool problems, the demands for her service in school can easily consume the major part of her time and attention. The teachers and principal may expect routine inspections for communicable disease by the nurse, the checking of absentees, weighing and measuring, and care of cuts and bruises. Supervisory assistance is required for interpreting to teachers and principals the relative value of health supervision of preschool and school children in their homes as compared with certain school nursing routines. The supervisor may help the nurse by:

1. Working out details of better management, such as (a) simplifying attendance records so that the teacher can without additional time give the nurse considerable information about absentees (b) collecting these records through a system of monitors so that they may be quickly gone over by the nurse (c) making them cumulative so that the nurse can easily see how frequently and for what reasons the children are absent.

2. Working out methods of obtaining the willing cooperation of teachers (a) in conducting their own daily inspections (b) in using such activities as weighing and measuring, simple first aid, and tests of hearing and vision for making health instruction more dynamic and meaningful.

3. Making available graphs showing the age-groups where mortality is highest for certain communicable diseases commonly considered school problems—such as diphtheria, scarlet fever, whooping cough, and measles. The local nurse can use such graphs in interpreting to the superintendent and the teachers how her time can be used most effectively when these diseases occur.

4. Making available significant information such as the proportion of children having preventable defects which developed during the antepartum, infant, and preschool periods.

5. Helping the nurse to devise methods of getting information resulting from her health observations of school children to the teachers

so that they may use it in their instruction and guidance of children.

6. Encouraging her to participate in case-study conferences with teachers in regard to children presenting problems—many of which are caused because of deviation from normal health.

BRINGING OUT EDUCATIONAL VALUES

A third problem has to do with the instructional value of the nurse's observations and service and her ability to make them available to the teachers. If the nurse is to make contributions of this sort she must know something about the curriculum and the objectives toward which the teachers are working. Obtaining this information takes time which should be spent in supervising the health of the family in the home. Consequently here is another area in which supervisory assistance is needed. The supervisor can learn what instruction is being given, and in which grades. With advance planning the service of the nurse and the instruction given in classes can reinforce each other in time, content and viewpoint.

An illustration of a situation in which this occurred was a school where the nurse's agency planned a tuberculin-testing program for the school children. The directors of the two agencies—the school and the health agency—made the initial plans. The supervisor of nursing worked out the details of the program, which included a careful study of the educational possibilities in school as well as outside the school. First she found out from the staff nurses what they knew about the tuberculin test and their attitude toward it. (Incidentally there were some of the staff who had never had the test themselves and who did not want to have it.) Then she worked with the school supervisor to find out what the teachers needed to know about the test and its implications. Following this the nurses, the teachers, and the respective supervisors devised a plan for including instruction on tuberculin testing as a part of a classroom unit on tuberculosis

and its control. Activities involved the distribution—through the children—of literature on tuberculosis in the homes.

Supervisory help is needed in showing other relationships between school health service and classroom instruction, and in working out some of the details which require time that neither the teachers nor the nurse have to give. Other health services, with their instructional possibilities, are as follows: the care of emergencies and the learning of first-aid procedures; health examinations and the study of human biology; immunization and the control of communicable disease, and the study of bacteria; the

follow-up of defects and the study of foods and nutrition.

INTERPRETING NURSING SERVICE

A fourth problem consists of interpreting the nurse's service to the school authorities and to the community in such a way that those concerned with the employment of public health nurses will be informed on what they may expect in quality of service. This involves constant vigilance on the part of supervisors in watching for opportunities to evaluate and to interpret school nursing as it contributes to the general public health program.

News from the S.O.P.H.N.'s

THE Michigan State Organization for Public Health Nursing held its sixth semiannual meeting at Grand Rapids on November 8, in conjunction with the Michigan Public Health Association. The S.O.P.H.N. met in the morning. A joint session was held in the afternoon and evening, with a program planned for the S.O.P.H.N. members as well as for physicians, nurses, dentists, and sanitarians who are members of the Public Health Association.

The attendance at our meetings increases each year as the counties throughout Michigan develop lay committees—or public health associations, as they may be called.

ACTIVE COMMITTEES

The Association has a Public Education Committee which is under the leadership of the wife of a local physician in a rural county. This committee held a luncheon session on November 8, attended by lay representatives from several counties with health departments. Each

of these women gave an interesting and instructive report of the activities in connection with the public health nursing program of her community. They plan to meet semiannually at the time of our meetings in the fall and spring. This committee will serve as a group of local public education workers for the organization and development of county and district health departments with qualified personnel. Alma C. Haupt, a speaker on the afternoon program, was present as a guest.

An Industrial Hygiene Committee was recently organized. One member is the chairman of the Nursing Section of the American Industrial Hygiene Association. The S.O.P.H.N. Committee will work jointly with this section in Michigan.

The Community Health Planning Committee has been organized about five years. The members are the presidents of the state organizations which have active health committees, such as the federation of women's clubs and the

parent-teacher association; the state commissioner of health and the director of the Bureau of Public Health Nursing; representatives and the directors of the public health nursing departments from the University of Michigan and Wayne University; and the director of public health nursing and a representative from each of the two foundations. Other representatives from state groups such as the Crippled Children Commission may be members.

The function of the committee is to work with representatives of other statewide organizations which have health programs in order to achieve a better coördination of existing services and the development of needed services not now

available. A subcommittee with representatives from the State Departments of Health, Public Instruction, and Welfare has been appointed to compile a register of the health facilities available for Michigan.

Regional institutes which have been sponsored by this committee are now being taken over for the most part by the county committees in the district and county health departments. The programs are developed by the committees themselves, with the assistance of the S.O.P.H.N. when requested.

EDNA L. HAMILTON, R.N.

*President, Michigan State
Organization for Public Health Nursing*

Your N.O.P.H.N.

THE EDITOR was conscious of a roomful of blue—the fresh, blue uniforms of an alert, interested group of nurses, ready to start on the day's work. She finished her short talk to the staff who were assembled for twenty minutes in the agency office to meet the N.O.P.H.N. visitor and hear something about their professional magazine—PUBLIC HEALTH NURSING.

"Where do you get the articles for the magazine?" asked an attractive young brown-eyed nurse on the back row.

"That is probably the most frequent question we are asked," replied the editor. "Most of our articles—eighty percent in 1939—are written especially for us. Where do we get the names of prospective writers? The members of the N.O.P.H.N. staff are constantly in the field, seeing interesting things that are being done by nurses in homes and schools and industrial plants and clinics. They bring back the names of people whose work our readers would like to hear about. The editor follows up these

suggestions and writes letters asking for articles."

"How do you select the writers of technical articles," queried a thoughtful nurse. "Articles on cerebral palsy or diabetes or syphilis for example. How can we be sure the articles in our magazine are reliable and authoritative?"

This evidence of healthy skepticism was delightful! "Every nurse," answered the editor, "has a right to ask herself that question in regard to everything she reads. The N.O.P.H.N. staff would not for a moment consider itself capable of selecting, unaided, the writers of all the magazine articles. Fortunately it has the help of the best medical and nursing authorities in the country for this important task. As you know, your Organization works through its sections and committees and councils. Its Council on Orthopedic Nursing, for example, includes recognized specialists in this field, both physicians and nurses. Their advice is available without cost to the N.O.P.H.N., to suggest names of author-

itative writers, to help us give aid to members with problems that arise, or to go over material intended for possible use in the magazine. (Of course, we now have an orthopedic nursing consultant also, through the generosity of the National Foundation for Infantile Paralysis.)

"Similarly in other fields we have the expert advice of our Council on Maternity and Child Health, and of the three sections—Industrial Nursing, School Nursing, and Board and Committee Members'."

"How did you get the recent series of articles on tuberculosis?" asked an earnest young Negro nurse.

"We have a close working relationship with the National Tuberculosis Association, which has its offices on the same floor as ours. The Association refers nursing problems in this field to the N.O.P.H.N., and the advice of its staff on medical questions is always available to us. The N.T.A. helped us plan this series of articles.

"We have a similar relationship with other national health agencies, many of whom also have offices near us. We are in fact part of a little family of national organizations known as the National Health Council. Our offices are all in Rockefeller Center. We have the benefit of expert advice on syphilis and gonorrhea from the American Social Hygiene Association, for example. For anything about eyes we turn to the National Society for the Prevention of Blindness. And of course we receive help on innumerable problems from the American Public Health Association.

"Your National Organization could not afford to have on its staff specialists in all the special health fields. But through its working relationship with other groups, the members and subscribers all have the benefit of the most recent, accepted knowledge on every health subject. I might add that we work very closely with our sister maga-

zine, *The American Journal of Nursing*, which is just across the hall, and with the other two nursing organizations nearby—the American Nurses' Association and the National League of Nursing Education."

"Who decides what you publish in regard to subjects on which there is a difference of opinion?"

"Our attitude on controversial subjects and all matters of policy is determined by our N.O.P.H.N. Publications Committee. Its 16 members include nurses, physicians, journalists, social workers, and lay people. The newest member is a staff nurse."

"Do you pay for articles?" asked a practical miss on the front row.

"No, we do not. We are a non-profit-making magazine, and in fact the N.O.P.H.N. has to subsidize the magazine about \$2000 a year in order to keep it out of the red. Therefore, we cannot afford to pay our authors. We have to depend on their generosity and their interest in public health nursing. But our requests for articles are rarely turned down. Incidentally, when a larger number of the 23,000 public health nurses and the lay people interested in public health nursing subscribe *individually* we shall have the money to do many more interesting things with the magazine—more pictures and a longer magazine for example."

"Is the number of subscribers increasing?" persisted the last questioner.

"Yes, indeed. In 1936 we had a circulation of 6000. Today it is 8000."

"Do people ever send in articles without being asked for them?" asked a supervisor.

"Many articles and papers are sent in voluntarily. Last year twenty percent of our articles were papers which had been given at state or local meetings, and twenty-two percent of all the articles and papers were offered voluntarily. Of course in the year of the biennial convention more papers are published."

"How many people are there on the editorial staff?" asked the chairman of the staff council, a pleasant, capable looking nurse.

"At present there is only one professional person whose major job is the magazine. She is responsible for securing articles, editing the manuscripts, and approving the final arrangement. She also writes editorials, introductory boxes, and other short items. Another member of the N.O.P.H.N. staff is editor of Reviews and Book Notes. The actual work of reading the proof, verifying the accuracy of figures and quotations and references, arranging the articles and pictures, and a thousand other details, is done by a non-nurse assistant on the magazine. But it would be incorrect to say that these three people comprise the magazine staff. All the members of the N.O.P.H.N. professional staff and the Board contribute in suggestions, evaluation of material, and actual writing of editorials, articles, reports, and accounts of meetings. And all of the clerical staff assist in one way or another with the infinite detail of the business end."

"Does the editor give all of her time to the magazine?"

"Oh, no, indeed. It is important for her to know what is going on in the field—what the problems of nurses are. In order to do this she attends meetings, goes on occasional field trips to observe what is being done by nurses on the job, and assists with the general correspondence. She also edits books and other publications of the Organization, and is responsible for seeing that bibliographies are kept up to date."

"How do you know what readers want?"

"That is indeed a real problem and it is one reason why I am here today. Nurses are busy people and somehow they seldom get time to write us what they think. If they do write, it is apt to be a brief note that does not tell us specifically what they found most useful,

what they want more of, and what they disagree with."

"But we do not feel that we know enough to write in to a national magazine and tell the editor what we think of it," protested one of the staff.

"That is just where you are mistaken. A magazine in order to be alive to the needs of its readers must know what they want. And as for the brickbats, we like them along with the bouquets. In fact they are really of more help to us. Nurses are probably too accustomed to accept without question whatever is given them. An analytical attitude is a wholesome one. Of course it must be thoughtfully so, with some basis for evaluation, in order to be of great value. But even an expression of likes and dislikes is helpful to an editor. You probably have little idea how seriously every comment is taken by the magazine staff. Perhaps nothing can be done about it at the moment because of budget limitations or previous plans. But it receives consideration and eventually may influence the policy of the magazine."

"During the past two years several nursing staffs like yourselves have made a careful study of the magazine in relation to their needs. Some of them have sent in very thoughtfully prepared reports which are invaluable to us. We hope more staffs will make such studies."

The clock on the mantel piece was ticking away the minutes and it was almost time for the nurses to start off on the day's round of work.

"Of course I don't need to tell this group," finished the editor, that PUBLIC HEALTH NURSING is the official journal of the National Organization for Public Health Nursing. It is your magazine, and it can be what you most want it to be if you will each assume a personal responsibility for telling us from time to time—if only on a postal card—what you are thinking and what you need for your job."

PURCELLE PECK, R.N.

NOTES *from the* NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

HOUSING AT THE BIENNIAL

Nurses planning to attend the Biennial Convention of the three national nursing organizations meeting in Philadelphia, Pennsylvania, May 12-18, 1940, may make arrangements for housing accommodations with the following committee chairmen:

Catholic Sisters — Sister M. Rita Quinan, chairman of the Subcommittee on Catholic Sisters, St. Joseph's Hospital, Philadelphia.

Deaconesses—Sister Margaret Fry, chairman of the Subcommittee on Deaconesses, Lankenau Hospital, Philadelphia.

Negro nurses—Lulu Warlick, chairman of the Subcommittee on Negro Nurses, 5000 Woodland Avenue, Philadelphia.

Men nurses—Sandy Mannino, chairman of the Subcommittee on Men Nurses, 1933 Tulpehocken Street, Philadelphia.

Student nurses — Beatrice Ritter, chairman of the Subcommittee on Student Nurses, Temple University, Philadelphia.

Sarah Krewson, chairman of the Subcommittee on Housing and Visitors, 2350 East Sergeant Street, Philadelphia. Miss Krewson will assist nurses in making housing arrangements, especially those desiring accommodation other than in hotels. Make your hotel reservation early.

Arrangements for breakfasts, lunches, and dinners may be made through Katie Walton, Philadelphia General Hospital, Philadelphia.

Mrs. Adelaide W. Pfromm, 1431 North 15 Street, Philadelphia, chairman of the Arrangements Committee, will be glad to answer any general inquiries about the convention.

WITH THE STAFF

Dorothy Deming went to Hartford, Conn., on December 6 to give a talk on cancer before the meeting of the State Public Health Association.

Evelyn Davis spoke on public health nursing at the luncheon of the Community Service in Scarsdale, N.Y., on December 5. On the thirteenth she spent the day in Portland, Me., speaking to the board and staff of the District Nursing Association in the morning and to a larger group interested in health in the afternoon. From there, she went to Manchester, N.H., and spent a day with the District Nursing Association and the Anna Cross League.

Virginia Jones continued her field trip on the West Coast during December. She went to Seattle, Wash., on December 3 to spend a week reviewing the program of study in public health nursing at the University of Washington and conferring with the state advisory nurse of the State Department of Health. On her way East, she stopped in Chicago, Ill., on December 12, to visit the University of Chicago.

A survey of the visiting nurse service in Hingham, Mass., was made by Ella L. Pensinger on December 4, 5, and 6. She went to Providence, R.I., on December 7 to attend the fifth regional conference of public health nursing executives from agencies with staffs of 20 or more.

Anna C. Gring attended the meeting of the Advisory Committee for the Revision of the Textbook and Instructors' Guide of the Home Hygiene and Care of the Sick Service at the American Red Cross headquarters in Washington, D.C., on December 11.

On December 7, Dorothy E. Wiesner went to Washington, D.C., at the request of the director of the Division of Statis-

(Continued on page 57)

ATTEND A GROUP CONFERENCE AT THE BIENNIAL

THE N.O.P.H.N. is planning a series of group conferences on various subjects on Saturday and Sunday, May 11 and 12, just preceding the Biennial Convention in Philadelphia. Reservations must be made before April 15 with the National Organization for Public Health Nursing, 50 West 50 Street, New York, N.Y. The following conferences will be given:

Business Administration. Leader, Lucretia H. Royer, N.O.P.H.N. business manager. Assistance from an expert in the field. Open to from 30 to 60 people, representatives from agency members, preferably business managers or directors. Only one representative from each agency member may attend.

Sessions: Sunday, May 12, afternoon.

Registration fee: \$1.50.

Industrial Hygiene. Leader to be announced later. Open to from 30 to 60 nurses.

Sessions: Saturday, May 11, all day.

Sunday, May 12, half day.

Registration fee: \$2 to N.O.P.H.N. members; \$4 to nonmembers.

Eye Health. Leader, Eleanor W. Mumford, associate for nursing activities, National Society for the Prevention of Blindness. Open to 35 supervisors or instructors in public health nursing, course or educational directors, and instructors in schools of nursing.

Sessions: Saturday, May 11, all day.

Sunday, May 12, half day.

Registration fee: \$2 to N.O.P.H.N. members; \$4 to nonmembers.

Maternity. Leader to be announced later. Open to from 30 to 60 nurses.

Sessions: Saturday, May 11, all day.

Sunday, May 12, half day.

Registration fee: \$2 to N.O.P.H.N. members; \$4 to nonmembers.

Orthopedic Nursing. Subject: Planning a staff education program in orthopedic nursing. Leader, Jessie L. Stevenson, N.O.P.H.N. assistant director. Open to 30 supervisors or nurses responsible for orthopedic program.

Sessions: Saturday, May 11, all day.

Sunday, May 12, half day.

Registration fee: \$2 to N.O.P.H.N. members; \$4 to nonmembers.

Records. Leader to be announced later. Open to from 30 to 60 people.

Sessions: Saturday, May 11, all day.

Sunday, May 12, half day.

Registration fee: \$2 to N.O.P.H.N. members; \$4 to nonmembers.

School Nursing.

Conference for nurses in the elementary schools. Leader, Marie Swanson, state supervisor of school nursing, New York State Education Department.

Conference for nurses in the secondary schools. Leader, Lula P. Dilworth, associate in health and safety education, New Jersey State Department of Public Instruction. Both conferences are open to from 30 to 60 nurses.

Sessions: Saturday, May 11, all day.

Sunday, May 12, half day.

Registration fee: \$2 to N.O.P.H.N. members; \$4 to nonmembers.

Social Hygiene. Leader to be announced later. Open to from 30 to 60 nurses.

Sessions: Saturday, May 11, all day.

Sunday, May 12, half day.

Registration fee: \$2 to N.O.P.H.N. members; \$4 to nonmembers.

Tuberculosis. Leader, Fannie Eshleman, supervisor of nurses, The Henry Phipps Institute, Philadelphia. Open to supervisors, educational directors, and directors of generalized and specialized public health nursing services.

Sessions: Saturday, May 11, all day.

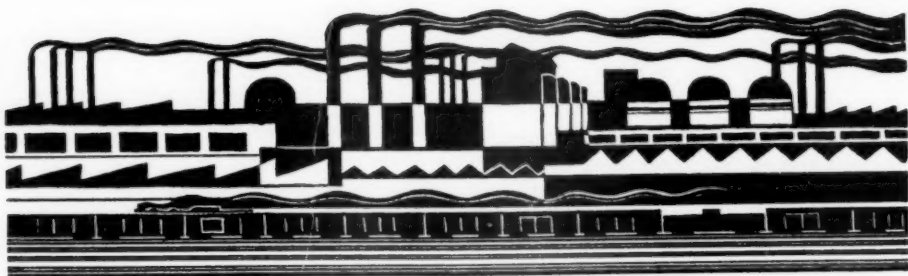
Sunday, May 12, half day.

Registration fee: \$2 to N.O.P.H.N. members; \$4 to nonmembers.

Registrations stating name, address, positions, N.O.P.H.N. membership if a member, name of institute, and registration fee should reach the N.O.P.H.N. office, 50 West 50 Street, New York, N. Y., before April 15. Registrations will be accepted in order of application and notification will be sent of acceptance.

(Continued from page 56)

tical Research of the U. S. Children's Bureau to discuss statistical reporting, especially with regard to the service to crippled children.



FIRST AID IN THE SMALL PLANT

An adequate first-aid program includes the education of the entire personnel and the delegation of responsibility to a competent person trained in the proper procedure

THE INFLUENCE which every individual in an industry exerts on a safety and health program is a factor in its success or failure. It is important that every employee be encouraged to report all injuries, however trivial they may seem. It is important that when the worker does report an injury he be greeted with a smile and complimented at having the good sense to come to the first-aid room promptly and to return until such time as the injury has completely recovered. It is essential that management and the department heads support the program because frequently a foreman who does not realize the importance of the care of minor injuries belittles the employee for reporting such injuries. It then becomes the duty of the nurse and safety committee and management to educate the foreman on this important matter. Finally, it is important for the nurse to recognize her limitations and to secure prompt and proper medical attention for injuries which require such care.

FIRST-AID TRAINING OF WORKERS

The training of employees in proper first-aid procedures develops a respect for the prevention of accidents, because the individual is taught to recognize the serious results which may occur from a

neglected scratch or an improperly treated wound. A well conducted first-aid program in a plant will bring results. If such a program is not already in effect, the nurse should do everything possible to convince the management and the individual employee of its value. The management must be sold on the plan, lest the individual worker feels that management is not supporting the program. The American Red Cross has done a splendid job in educating industries to the importance of adequate first aid.

In industries which do not have an industrial nursing service there is no professional person at the plant to care for injuries. In such plants it is important to have persons other than physicians and nurses trained and interested in the subject of first aid.

Who, then, is the logical person to be trained? That is one of the problems confronting those who are interested in the safety program of the small industry. Frequently it is the time-keeper, since he is available most of the time, is familiar with the individual employee, and receives a certain amount of recognition as a key person in the industry. He may be a satisfactory person to assume the responsibility if he has had training in first aid, has common sense, recognizes the importance of caring for minor injuries, and knows his limitations.

Fortunately today there are fewer

so-called "doc's" in plants, who consider it their duty to assume responsibilities which belong to a physician. We now hear less often the phrase, "Oh, we don't worry about eye cases here; Jim in the tool room is as good as any doctor and he has been doing this for years. We always go to him when we have something in our eye." Goggles have lessened the number of eye injuries, and employees are loathe to allow any unskilled person to touch their eyes, due to the teaching of the safety committees, insurance carriers, physicians, and others interested in giving the employees the best possible medical attention.

A former boy scout makes a good first-aid-er, provided he has kept up to date on his first-aid procedures. Any individual who has received instruction in first aid from the American Red Cross may be a good person to give first aid in the small plant—whether there are 10 employees or 100. Certain it is that the small plant needs to place the responsibility for first aid on a qualified individual. Lives are just as important in the small industry as in the large one.

When the employer's attention is called to the importance of this first-aid training in the smaller industry, he frequently remarks, "Oh, we don't need first-aid treatment here, we send everything to the doctor." That might be a satisfactory plan if it were true. The frequency of medical calls of that plant would, however, be terrific. Experience has shown that for a plant of 50 persons, especially in the machine industry, there occur at least 10 to 15 minor injuries daily that should receive first-aid attention. If no material is available to care for these injuries and if no person is available, they must go untreated or perhaps be cared for at home after working hours. From this source come many serious results from the use of iodine which has become con-

centrated or from carbolic ointments or other inappropriate first-aid measures.

The first-aid training received by employees in early life is of great value in the prevention and treatment of industrial accidents. It is a satisfaction to see groups of girl scouts and boy scouts receiving their first-aid training, because of the important place which this phase of their education will play later in life. The workers who have had no previous training may be taught in first-aid courses for adults such as the American Red Cross classes.

The foreman and supervisory group are reached through the safety committee, the medical director, the nurse, and—in the smaller plants—the foreman. Visual education in the form of posters, messages, and first aid and safety films is an excellent method of teaching first aid to both small and large groups. Recently a first-aid man stated that the reports of injuries in his plant had doubled since the employees had seen the film "Open for Infection."* This did not indicate that injuries had increased, but only that the men were more eager to report them.

COORDINATE FIRST AID AND SAFETY

The first-aid program should be closely associated with the safety program, and reports of minor injuries should receive as much attention from the safety committee as more serious injuries. A repetition of the same type of apparently trivial injuries from the same department and especially from the same person indicates a need for closer observation on the part of the safety committee. The attention to details in this matter may divert a serious accident. The report may indicate a frequency of eye cases from one or more departments. This should stimulate

* This film was prepared by the National Safety Council, 20 North Wacker Drive, Chicago, and is available at a reasonable rental fee.

action on the part of the committee to eliminate the conditions causing these injuries. A frequency of burns indicates the necessity for closer attention to protective clothing.

Records are the barometer indicating the effectiveness of the safety program and serve as a compass to chart its activities.

Industries should be classified for first-aid setup according to their size and personnel. Plants having full- or part-time medical supervision usually have their first-aid problems well in hand. Smaller industries, which are by far the more frequent, need to pay closer attention to this problem. The practice of having first-aid material scattered about the plant in tool kits with no one person responsible is a contributing factor in a poor plant safety record.

FIRST-AID EQUIPMENT

First-aid kits should be readily accessible. They should be near running water and in a well lighted location. The supplies should be simple. The kit should be well constructed and made of material which is easily cleaned, and it should be kept clean. There are certain minimum requirements which should be considered as essential. In general it may be stated that the following articles, modified to suit local conditions and needs, should be included in the emergency supplies:

- Clean bandages kept in a clean container
- Sterile gauze in individual packages and a larger roll for emergencies only
- Tweezers and scissors
- Adhesive tape
- Absorbent cotton (preferably cotton balls kept clean in a covered container)
- Tourniquet
- Hot-water bottle
- Paper cups
- Clean applicators in clean containers
- A stimulant such as aromatic spirits of ammonia for use in fainting or shock
- Application for first-aid treatment of burns
- Antiseptic for emergency use on wounds, cuts, and scratches

The application for burns and the antiseptic used may be chosen by the physician who serves the plant. If iodine is used, it should be purchased only in very small amounts and not allowed to become concentrated. Sterile needles kept in small glass bottles are useful in removing small splinters of wood or steel. All imbedded splinters should be sent to a physician for the proper removal, as they are frequently a source of infection. Splints should be readily available, as well as a stretcher and a warm wool blanket. The last three are important in every type of industry and are frequently neglected. The stretcher and blanket should be kept at all times in a clean container in a location with which everyone is familiar, and should be conspicuously labeled.

A few points frequently neglected in first aid should be emphasized:

1. The care of the eyes is very important. In the case of burns by chemicals—caustic or acid—the eye should be flushed with sterile water repeatedly, with the lid turned back so that the water reaches all of the tissues; then with a neutralizing agent. The patient should be sent to an oculist, if one is available; otherwise to a general physician. All foreign bodies embedded in the eyes should receive prompt medical attention. The eye should be closed with a light dressing over it and the patient sent to a physician. Loose particles may be removed by turning back the lid and wiping them off gently with a clean applicator moistened with clean water or boric acid solution. If the foreign body is on the cornea, however, it should be flushed off with the water or solution, and if it cannot be dislodged in this way it should be treated as if embedded. If the foreign body has been removed by the nurse, the worker treated should be asked to return within an hour in order to determine whether there are any particles re-

maining, and if there is any doubt at all he should be sent to a physician.

2. The use of a tourniquet should be taught every employee, as more harm has been done by an improperly applied tourniquet than by the injury itself. Wires and ropes should never be used as tourniquets. Pressure should be applied no longer than 10 or 15 minutes at a time.

3. Fractures should be splinted without moving the patient. If he is out of danger and kept warm and comfortable, it is better to allow him to lie quietly until skilled help arrives. If the injured person requires hospital care, the physician who is to attend the patient should be called to learn what hospital he wishes the patient transferred to. This will add to the patient's comfort, and prevents complications due to repeated moving.

It is known that a large proportion of all industrial injuries occur to the hands and fingers. The nurse can aid in the elimination of this vast loss by encouraging immediate reporting of all injuries, thus securing early first aid and prompt medical attention. Hand injuries require skilled medical attention and should be given close supervision until the time of their recovery.

DERMATITIS

It is estimated that four million dollars are spent for industrial dermatitis in the United States each year.* The nurse who is interested in safety and first aid can do a great deal to aid in the elimination of this troublesome situation by the following methods:

1. Chemicals and other irritants should be kept off the skin as much as possible. This may be accomplished by mechanical handling and by protective clothing. Where these safeguards are not possible, protective ointments may be used.

* Schwartz, Louis. "Industrial Dermatitis." *National Safety News*, November 1937, p. 34.

2. In case these irritants do come in contact with the skin, they should be removed by flushing with plenty of plain water.

3. Should dermatitis occur in spite of these precautions, the employee should be instructed to report to the foreman immediately.

4. Early medical attention should be given, as a cure is more easily effected in the early stages than in a chronic condition. Self-medications should not be attempted, because of the hazard of cross-infection.

5. A change of employment is essential if the individual is especially susceptible and does not respond to treatment. Careful observation and the daily checking of arms and hands of workers who are employed in departments where such hazards exist should be carried out.

It is important that written standing orders for procedures of first-aid treatment in a plant be approved by the physician who serves the plant.

The influence which is brought about by first-aid training does not by any means limit itself to industry. In view of the fact that 31,500 persons were killed and 140,000 permanently maimed or crippled by accidents in the homes in 1938,* first-aid training becomes important in the home. Persons well versed in first-aid treatment will also be interested in lessening the tragic accident toll on the highway as well as in the home.

Let us teach proper and adequate first aid and use it as a means of defense against waste, want, and misery.

JOANNA M. JOHNSON, R.N.
Employers Mutuals
Milwaukee, Wisconsin

*National Safety Council. *Accident Facts*. Chicago, Illinois, 1939, p. 54.

Presented before the School of First Aid and Health, Milwaukee Association of Commerce, Milwaukee, Wisconsin, May 29, 1939.



SUPERVISION IN PUBLIC HEALTH NURSING

By Violet H. Hodgson. 376 pp. The Commonwealth Fund, New York, 1939. \$2.50.

This book covers every aspect of supervision and is a distinct contribution to public health nursing literature. It is written "especially for the guidance of the supervisor in her efforts to promote the professional growth of the nurse." For the young supervisor and those who are experienced, the book should be a wellspring of information and inspiration. Administrators, too, will find it helpful and enlightening. It should also prove an invaluable aid in discussion groups, and for more formal classroom study.

The success of public health nursing programs depends to a considerable extent upon the preparation and efficiency of the supervisor. The author reviews the academic and professional requirements of this worker and the more intangible personal qualifications which make a successful leader.

The prime objectives of supervision are described as "the maximum development of the nurse into the most competent person professionally she is capable of becoming" at all times, together with intelligent joint effort in serving the public. The methods of supervision which are discussed are therefore democratic and based upon sound educational principles.

In order to define the framework within which the supervisor works, principles of organization and administration are presented in a masterly fashion. The place of the consultant and special supervisor in an agency setup is also considered. A generous use of diagrams adds interest and clarity to the text. Attention is given to the peculiar problems of the supervisor in both official

and voluntary agencies and in urban and rural situations.

An analysis of the supervisor's job, both teaching and administrative, is profusely illustrated with examples from the field. The wealth of material at the author's command is woven into a pattern which is beautifully clear, rich, and meaningful. She has set high standards but they are within the realm of the practicable.

The ultimate goal of supervision is here, as always, better service to the patient, the family, and the community. The entire book bears the hallmark of authenticity. The author *knows* whereof she speaks.

GLADYS L. CRAIN, R.N.
Buffalo, New York

FIGHTING FOR LIFE

By S. Josephine Baker, M.D. 264 pp. The Macmillan Company, New York, 1939. \$2.75.

Here is a graphic story of a pioneer woman physician in the field of public health in this country. Many glimpses of the difficulties women had in seeking not only a place in the medical profession but even the right of the ballot are given in her account of medical school and internship days in New York, and later of her gradual rise under many difficulties from the position as medical inspector of the Department of Health of New York City to that of chief of the Division of Child Hygiene. She was the first woman "to be appointed to an administrative position in government in this country, where she established the principles of baby and child care as a function of the state."

Her account of her assignment to get the first specimens from "Typhoid Mary" is delightfully humorous.

Public health nurses, health officers, and in fact all those engaged in public

health and its allied professions will get new ideas and take new heart in reading how Doctor Baker and her staff tackled the problems which they are now facing in areas where present health conditions are similar to those in New York City in the early part of this century.

EVA F. MACDOUGALL, R.N.
Indianapolis, Indiana

IMPROVISED EQUIPMENT IN THE HOME CARE OF THE SICK

By Lyla M. Olson. 264 pp. W. B. Saunders Company, Philadelphia, third edition revised, 1939. \$1.50.

In the third revision of her book the author has added one hundred and forty-five sketches with as many suggestions for improvization of equipment. A new feature is the inclusion of rhymed playlets and suggestions for exhibits. The book is not limited to equipment used in the care of the sick but contains many suggestions for the daily life in the home. The private duty nurse, the public health nurse, and the nurse teaching organized groups will all find this book useful.

BESSIE NICOLL, R.N.
Toledo, Ohio

THE BUILDING OF A NATION'S HEALTH

By Sir George Newman. 479 pp. Macmillan and Company, Ltd., London, England, 1939. \$6.

The author was formerly England's chief medical officer of the Board of Education, and also of the Ministry of Health. This book is based on documentary references. But the author's English prose is so clear and rhythmic, and the story of the progress in health services is so dramatic that many nurses will find reading it a pleasure.

The book gives in detail the historical background and development of medical education and practice, and health services.

Nurses will be particularly interested in the chapters on School Medical Service, The Mother and Her Infant, Nutrition, The Industrial Worker, and Health

Insurance. Public health nurses may be disappointed that there is no chapter devoted to nursing service, though there are occasional references to the work of the nurse in the different programs.

One impression is outstanding of the book as a whole: the value of the English civil servant, whose qualifications for his job and whose devotion to his work are largely responsible for the great strides in health progress.

The book will be enjoyed by many nurses and the index will enable those fortunate ones who own it to refer to it frequently for facts and inspiration.

LOUISE KNAPP, R.N.
Detroit, Michigan

CHILDREN FROM SEED TO SAPLINGS

By Martha May Reynolds. 337 pp. McGraw Hill Book Company, New York, 1939. \$2.50.

The title of this book gives happy augury of the contents: comparatively brief summaries of a child's life through the successive stages of development from conception to eighteen years. Throughout the book, the author focuses attention on the child himself, reminding us that he is the original source of information at any age.

The reader is encouraged to develop his powers of discovery and to observe the opportunities open to a better understanding of oneself through the study of children. He is assisted by suggestions in the technique of studying children and directed to a bibliography of selected readings.

The child, in his daily activities and in each stage of development, is discussed with a warmth and simplicity which should prove reassuring to parents. In reading Chapter Six, Eight Year Olds—The Transition Stage, and Chapter Seven, The Unknown Age, which are particularly rewarding, one has the feeling that the children are presented as they most happily might have presented themselves.

"That each age is a transition between the one the child has grown out of and the one he is soon to grow into" is stressed. The emphasis on the whole span of growth and the contribution each age makes to the understanding of children at any age should make this book of value for reference reading in public health nursing and for parent study groups.

FRANCES H. BENJAMIN
New York, New York

CHOICE AND CHANGE OF DOCTORS

By Gladys V. Swackhamer. 47 pp. Committee on Research in Medical Economics, Inc., 9 Rockefeller Plaza, New York, 1939. Free

The Committee on Research in Medical Economics has sponsored this fact-finding study in the hope that other agencies will be stimulated to make similar inquiries. They, themselves, are now conducting a parallel investigation in a much smaller city.

In the present study it was found that many families cling to the idea of a "family doctor." But less than one third of them thought that they had such a doctor and among the other third the doctor-patient relationship was tenuous. The reader is invited to judge for himself how far these findings are applicable to other economic and geographic groups.

J. ROSSLYN EARP, M.D.
Albany, New York

ESSENTIALS OF PEDIATRICS

By Philip C. Jeans, M.D., and Winifred Rand, R.N. 521 pp. J. B. Lippincott Company, Philadelphia, third edition, 1939. \$3.

Outstanding features of this book are the description of the normal, growing child and the sympathetic discussion of the nurse's relationship to the well or sick child as a factor in guidance and treatment. Suggestions throughout include the ideal, but are also practical and reveal an awareness of the child in

his environment—be that home, clinic, or hospital.

Information on nutrition and the treatment and control of disease has been brought up to date. All material is well presented and illustrated. The book stimulates one to read further, so that a bibliography would enhance its value. It is a sane, well balanced textbook.

IRENE CARN, R.N.
Cambridge, New York

PUBLIC HEALTH LAW

By James A. Tobey, Dr.P.H. 414 pp. The Commonwealth Fund, New York, 1939. \$3.50.

Public health law is a field in which there has been available to American students in recent years only a single comprehensive volume, the first edition of this work.

This second edition retains the good features of the 1926 edition but has been rewritten in order to recognize the tremendous recent expansion in the scope and influence of public health laws. Public health nurses will find the general sections comprehensive and lucid, and will be especially interested in the chapters on school hygiene, vaccination, communicable disease control, vital statistics, and the legal aspects of personnel management. The volume can be recommended.

REGINALD M. ATWATER, M.D.
New York, New York

FOOD VALUE CHARTS

The six food value charts in black and white prepared by the Philadelphia Child Health Society are again available from the Society, 311 South Juniper Street, Philadelphia, Pa. The charts, four of which were reproduced in the article, "Helping Families on Small Food Budgets," October issue, page 537, are 8½ x 7 inches in size. Since new data indicate that a revision of the charts will not be necessary as announced, the original set is again available. Nurses will find these charts helpful teaching materials for use in schools, with families, or in mothers' classes.



• Graduate nurses who are interested in making application to Teachers College for the Isabel Hampton Robb Fellowship should file formal application with the Secretary of Teachers College, Columbia University, New York, N.Y., by January 15, on forms which will be sent on request.

The Isabel Hampton Robb Fellowship, which for the year 1940-1941 will amount to \$550, is awarded at the discretion of the Committee on Fellowships and Scholarships of Teachers College to an advanced student in Nursing Education. The fund from which this fellowship is derived was originally subscribed by the members of the national nursing associations for the purpose of endowing a chair in Hospital Economics in Teachers College. It was later assigned to the College as a fellowship fund in memory of Mrs. Robb.

Since the fellowship is for the purpose of encouraging advanced study in Nursing Education, applicants will be required to give evidence of their qualifications to pursue advanced study. They should be prepared to devote a portion of their time in the College to the study of some special problem.

• Recommendations for candidates for the next award of the Walter Burns Saunders Memorial Medal to a member of the American Nurses' Association for "distinguished service in the cause of nursing," should be made by January 20. Suggestions may be sent to the American Nurses' Association, 50 West 50 Street, New York, N.Y.

• The Fourth National Social Hygiene Day will be observed on February 1. Suggestions, free kits of program and publicity aids may be obtained from the

American Social Hygiene Association, 50 West 50 Street, New York, N.Y.

• The American Orthopsychiatric Association will hold its seventeenth annual meeting at the Hotel Statler, Boston, Mass., February 22-24. Further information about the meeting may be obtained from Dr. Norvelle C. LaMar, 149 East 73 Street, New York, N. Y.

• Child Labor Day is to be observed January 27-29. Suggested programs and material for the observance of Child Labor Day may be obtained from the National Child Labor Committee, 419 Fourth Avenue, New York, N. Y.

• An industrial nursing section was organized at the annual meeting of the Georgia State Organization for Public Health Nursing, in Savannah, November 13; and these officers were elected:
Chairman—Ruby Falls, Chicopee Mills, Gainesville.

Vice-chairman—Jennie Murphy, Union Bag and Paper Corporation, Savannah.

Secretary—Vada Hannah, Swift Manufacturing Company, Columbus.

• A joint dinner meeting of the Industrial Relations Association of Wisconsin and the Industrial Nurses' Division of the Public Health Section of the Wisconsin State Nurses' Association was held on November 8 in Milwaukee. The following officers were elected:

Chairman—Agnes R. Moroney, Milwaukee.

Vice-chairman — Ruth Winters, Joseph Schlitz Brewing Company, Milwaukee.

Secretary—Agnes Laufer, Line Material Company, South Milwaukee.

ERRATUM: Omission was made of the fact that "Studying the Quality of Nursing Service" by Margaret Reid, page 668 of the December 1939 issue, was presented at the eleventh annual meeting of the New England Division of the American Nurses' Association in Providence, R.I., on June 6, 1939.

Official Directory of Public Health Nurses

Listing those holding executive positions in the Federal Government, in national organizations, and in states and territories, officers of state organizations for public health nursing and public health nursing sections of state nurses' associations, and directors of public health nursing courses

Information as of December 1, 1939, unless otherwise stated.

National Organization for Public Health Nursing, Inc.

President, Grace Ross, City Department of Health, 3919 John R Street, Detroit, Mich.
General Director, Dorothy Deming, 50 West 50 Street, New York, N.Y.

American Red Cross, Nursing Service

National Director, Mary Beard, American Red Cross, National Headquarters, Washington, D.C.
Assistant Director, Virginia Dunbar, American Red Cross, National Headquarters, Washington, D.C.
Assistant Director, Helen Dunn, American Red Cross, National Headquarters, Washington, D.C.
Assistant to National Director, Annabelle Petersen, Enrollment, American Red Cross, National Headquarters, Washington, D.C.
Assistant to National Director, Marie Peterson, Enrollment, American Red Cross, National Headquarters, Washington, D.C.

Eastern Area

(All to be addressed at American Red Cross, National Headquarters, Washington, D.C.)

Director, Lucy Massey.

Assistants to the Director:

Mary DeLaskey.
Virginia Elliman.
Eugenia Klinefelter.

Nursing Field Representatives:

Bertha Allwardt—New York.
Zella Bryant—Kentucky, Louisiana, Mississippi, Tennessee.
(Vacant)—Indiana, Ohio, Virginia, West Virginia.
Alice Dugger—Alabama, Florida, Georgia, North Carolina, South Carolina.
Elizabeth Hill—Delaware, Maryland, Pennsylvania.
Mrs. Charlotte Heilman—New Jersey.
Frances Crouch—Massachusetts, Rhode Island, Vermont.
Hazel V. Dudley—Connecticut.
Winifred Bonham—Maine, New Hampshire.

Midwestern Area

(All to be addressed at American Red Cross, 1709 Washington Avenue, St. Louis, Mo.)

Director, Cecelia Walsh.

Assistants to the Director:

Ella B. Gimmetad.
Thora Ingebritson.

Nursing Field Representatives:

Rebecca Pond—Illinois, Michigan, Minnesota, Wisconsin.
Rose Schladweiler—Missouri, Kansas, Colorado, New Mexico.
Ann Magnussen—Iowa, Montana, Nebraska, North Dakota, South Dakota, Wyoming.
Lorena Jane Murray—Oklahoma, Colorado, New Mexico, Arkansas, Texas.

Pacific Area

(All to be addressed at American Red Cross, Civic Auditorium, Larkin and Grove Streets, San Francisco, Calif.)

Director, Gladys L. Badger.

Assistant Director, Myrtis Coltharp—Arizona, California.

Nursing Field Representative, Helen Peters—Idaho, Nevada, Oregon, Utah, Washington.

National Association of Colored Graduate Nurses, Inc.

President, Mrs. Frances F. Gaines, 649 East 50 Place, Chicago, Ill.

Executive Secretary, Mabel K. Staupers, 50 West 50 Street, New York, N.Y.

U. S. Department of the Interior Bureau of Indian Affairs

Acting Director of Nursing, Sallie Jeffries, Office of Indian Affairs, Department of the Interior, Washington, D.C.

Associate Public Health Nursing Consultant, Rosalie I. Peterson, Office of Indian Affairs, Department of the Interior, Washington, D.C.

Field Nurse Supervisor, N. Helen Phelps, Care of Five Civilized Tribes Indian Agency, Muskogee, Okla.

Assistant Field Nurse Supervisor, Beulah Oldfield, Care of Five Civilized Tribes Indian Agency, Muskogee, Okla.

District Supervisory Nurses:

Mary E. McKay, 102 Federal Office Building, San Francisco, Calif.

Gertrude F. Hosmer, Post Office Box 527, Albuquerque, N. Mex.

(Vacant), 218 Federal Office Building, Minneapolis, Minn.

U. S. Department of Labor

Children's Bureau, Public Health Nursing Unit—Director of Public Health Nursing, Naomi Deutsch, Children's Bureau, Department of Labor, Washington, D.C.

Regional Public Health Nursing Consultants and Territory

(To be addressed at Children's Bureau, Department of Labor, Washington, D.C.)

Hortense Hilbert—Maine, New Hampshire, Vermont, Massachusetts, New York, Connecticut, Rhode Island, Pennsylvania, New Jersey.

Ruth Heintzelman—Maryland, Delaware, Virginia, West Virginia, North Carolina, South Carolina, Georgia, Florida, District of Columbia.

Jane Nicholson—Illinois, Indiana, Ohio, Iowa, Michigan, Minnesota, Wisconsin, North Dakota, South Dakota, Nebraska.

Ruth Cushman, Room 1048, 210 Baronne Street, New Orleans, La.—Kentucky, Tennessee, Alabama, Louisiana, Arkansas, Mississippi, Oklahoma, Texas, Kansas, Missouri.

Alice F. Brackett, Room 1206, 785 Market Street, San Francisco, Calif.—Arizona, New Mexico, Colorado, Montana, Wyoming, Idaho, Nevada, California, Oregon, Washington, Utah, Territories of Alaska and Hawaii.

U. S. Department of the Treasury

Bureau of the Public Health Service, Public Health Nursing Service

Senior Public Health Nursing Consultant, Pearl McIver, U. S. Public Health Nursing Service, Washington, D.C.

Public Health Nursing Consultant, Helen Bean, U. S. Public Health Nursing Service, Washington, D.C. (On leave of absence.)

Regional Public Health Nursing Consultants and Territory

Mary D. Forbes, Sub-Treasury Building, Wall, Pine, and Nassau Streets, New York, N.Y.—Maine, New Hampshire, Vermont, Massachusetts, Connecticut, Rhode Island, New York, New Jersey, Pennsylvania.

Mary J. Dunn, 1413 Park Road, Northwest, Washington, D.C.—Delaware, Maryland, West Virginia, Virginia, North Carolina, South Carolina, Georgia, Florida, District of Columbia.

F. Ruth Kahl, Room 314, U. S. Court House, Chicago, Ill.—Ohio, Indiana, Illinois, Michigan, Wisconsin, Iowa, Minnesota, Nebraska, North Dakota, South Dakota.

Donna Pearce, 210 State Street, New Orleans, La.—Alabama, Mississippi, Louisiana, Tennessee, Kentucky, Missouri, Arkansas, Oklahoma, Kansas, Texas.

Anna Heisler, Room 112, Federal Office Building, San Francisco, Calif.—California, Oregon, Washington, Idaho, Nevada, Utah, Montana, Wyoming, Colorado, New Mexico, Arizona, Alaska, Hawaii.

U. S. Veterans' Administration

Veterans' Administration Nursing Service—Superintendent of Nurses, Mrs. Mary A. Hickey, Veterans' Administration, Washington, D.C.

ALABAMA

Section on Public Health Nursing of State Nurses' Association—Chairman, Margaret Nations, State Board of Health, Montgomery. Secretary, Marion Ferrell, Anniston.

State Department of Public Health—Pearl Barclay, Associate Director of Public Health Nursing, Division of Hygiene and Public Health Nursing, Montgomery.

State Nurses' Association Paid Executive—Anne Beddow, 1601 North Twenty-fifth Street, Birmingham.

ARIZONA

Section on Public Health Nursing of State Nurses' Association—Chairman, Caroline Kammerer, 307 West Ventura Street, Tucson. Vice-Chairman, Mrs. Bertha LaFleur, School Nurse, Globe. Secretary, Molly B. Smith, 28 East Corral Street, Tucson.

State Board of Health—Jefferson I. Brown, Chief Public Health Nursing Consultant, Division of Local Health Work, Phoenix.

ARKANSAS

State Organization for Public Health Nursing—President, Mrs. Lila Sallee, State Board of Health, Little Rock. Secretary, Mrs. Angie Faye Waldrum, City Health Department, Little Rock. Treasurer, Opal Matthews, Fayetteville. Chairman Membership Committee, Katherine Justus, Helena.

State Board of Health—Margaret Vaughan, Supervisor of Public Health Nursing, Bureau of Local Health Service, Little Rock.

CALIFORNIA

State Organization for Public Health Nursing—President, Ruth W. Hay, University of California, Berkeley. Secretary, Inalene M. Snow, 1636 Bush Street, San Francisco. Treasurer, Janet M. Roush, 726 N. Tuxedo, Stockton.

State Department of Public Health—Rena Haig, Chief, Public Health Nursing Service, 305 State Building, San Francisco.

California Tuberculosis Association—Irene E. Carlson, 45 Second Street, San Francisco.

State Nurses' Association Paid Executive—Harriett L. P. Friend, Director at Headquarters, Room 309, 609 Sutter Street, San Francisco.

COLORADO

Section on Public Health Nursing of State Nurses' Association—Chairman, Mrs. Gertrude S. Tyler, 314 Fourteenth Street, Denver. Vice-Chairman, Mrs. Laura D. Looms, 771 Franklin, Denver.

State Division of Public Health—Ruth Phillips, Director, Division of Public Health Nursing, 424 State Office Building, Denver.

Colorado Tuberculosis Association—Mrs. L. Louise Gaghagen, 305 Barth Building, Denver.

State Nurses' Association Paid Executive—Irene Murchison, 621 Majestic Building, Denver.

CONNECTICUT

Section on Public Health Nursing of State Nurses' Association—Chairman, Dorris Weber, 35 Elm Street, New Haven. Vice-Chairman, A. Elizabeth Bigelow, 69 East Main Street, Meriden. Secretary, Clara G. Christie, 20 Lincoln Street, New Britain.

State Department of Health—Hazel V. Dudley, Director, Bureau of Public Health Nursing, State Office Building, Hartford.

State Nurses' Association Paid Executive—Margaret K. Stack, Room 512, 252 Asylum Street, Hartford.

DELAWARE

Section on Public Health Nursing of State Graduate Nurses' Association—Chairman, Grace Murray, State Board of Health, Dover. Vice-Chairman, Mildred Willey, 911 Delaware Avenue, Wilmington. Secretary, Edith Kerwien, 926 West 7 Street, Wilmington.

State Board of Health—Grace Murray, Acting Director, Public Health Nursing, Dover.

DISTRICT OF COLUMBIA

Public Health Section of the Graduate Nurses' Association—Chairman, Lillian M. Bischoff, 1307 Saratoga Avenue, Northeast, Washington. Secretary, Mrs. Margaret Roth Heiney, 318 Rhode Island Avenue, Northeast, Washington.

District of Columbia Health Department—Mrs. Josephine Prescott, Director, Bureau of Public Health Nursing, Washington.

District of Columbia Tuberculosis Association—Mrs. Ernest R. Grant, 1022 Eleventh Street, Northwest, Washington.

District Nurses' Association Paid Executive—Edith M. Beattie, 1746 K Street, Northwest, Washington.

FLORIDA

Section on Public Health Nursing of State Nurses' Association—Chairman, Mrs. Lydia Holzschlechter, New Port Richey. Vice-Chairman, Mrs. Mary Matthews, Duval County Health Unit, Jacksonville. Secretary, Mrs. Sarah M. Bray, Brooksville.

State Board of Health—Ruth Mettinger, Director, Bureau of Public Health Nursing, Jacksonville.

GEORGIA

State Organization for Public Health Nursing—President, Mrs. Eudelle Trawick, Sparta. Secretary, Caroline Tillinghast, Swainsboro. Treasurer, Mary Johnston, Bibb County Health Department, Macon. Chairman Membership Committee, Charlotte Ingleby, Savannah Health Center, Savannah.

State Department of Public Health—Mrs. Abbie Roberts Weaver, Director, Division of Public Health Nursing, State Capitol, Atlanta.

State Nurses' Association Paid Executive—Durice Dickerson, 131 Forrest Avenue, Northeast, Atlanta.

IDAHO

State Division of Public Health—Mrs. Kathryn McCabe, Director, Division of Public Health Nursing, Boise.

Idaho Anti-Tuberculosis Association—Margaret Thomas, 211 Capitol Securities Building, Boise.

ILLINOIS

Section on Public Health Nursing of State Nurses' Association—Chairman, Mabel McClenahan, 709 Cowles Avenue, Joliet. Vice-Chairman, Ruth Ostrom, 1531½ Third Avenue, Moline. Secretary, Hester Nicoles, 211 Richards Street, Joliet.

State Department of Public Health—Maude Carson, Chief Supervising Nurse, Division of Child Hygiene and Public Health Nursing, Springfield.

State Nurses' Association Paid Executive—Edith A. Bergquist, 8 South Michigan Avenue, Chicago.

INDIANA

Section on Public Health Nursing of State Nurses' Association—Chairman, Nina Douglass, 1115 Sunnymede, South Bend. Vice-Chairman, Marie Winkler, 808 Majestic Building, Indianapolis. Secretary, Mary Helen Kennerk, 611 South 11 Street, Newcastle.

State Board of Health—Eva MacDougall, Chief, Bureau of Public Health Nursing, Indianapolis.

State Nurses' Association Paid Executive—Helen Teal, 1125 Circle Tower, Indianapolis.

IOWA

Section on Public Health Nursing of State Nurses' Association—Chairman, Alice Miller, Court House, LeMars. Vice-Chairman, Marie Pound, Manchester. Secretary, Corda Voris, Room 10, City Hall, Des Moines.

State Department of Health—Edith S. Countryman, Director, Division of Public Health Nursing, Des Moines.

Iowa Tuberculosis Association—Marguerite Pfeiffer, 610 Flynn Building, Des Moines.

KANSAS

Section on Public Health Nursing of State Nurses' Association—Chairman, Nellie Jewell, 408 Back Bay Boulevard, Wichita. Vice-Chairman, Mary E. McAuliffe, State Board of Health, Topeka. Secretary, Mrs. Irene Kimel, 1149 University, Wichita.

State Board of Health—Mary E. McAuliffe, Supervisor, Public Health Nursing, Division of Child Hygiene, Capitol Building, Topeka.

KENTUCKY

State Organization for Public Health Nursing—President, Mrs. Carrie B. Hunt, Jefferson County Health Department, Louisville. Secretary, Mrs. Will B. Carrico, 620 South Third Street, Louisville. Treasurer, Mrs. Luile Fentress, Muhlenberg County Health Department, Bowling Green. Chairman Membership Committee, Nancy Cummings, Fayette County Health Department, Lexington.

State Department of Health—Margaret L. East, Director, Bureau of Public Health Nursing, Louisville.

State Nurses' Association Paid Executive—Mrs. Myrtle C. Applegate, 604 South Third Street, Louisville.

LOUISIANA

State Organization for Public Health Nursing—President, Laurence Bernard, St. Mary Parish Health Center, Franklin. Secretary, Celine McGinn, 313 Civil Court Building, New Orleans. Treasurer, Peggy Stuart, 2118 Cadiz Street, New Orleans.

State Department of Health—Emma Maurin, Director, Division of Public Health Nursing, Bureau of Parish Health Administration, New Orleans.

MAINE

Section on Public Health Nursing of State Nurses' Association—Chairman, Lucy A. Barker, 268 Main Street, Waterville. Vice-Chairman, Gwendolyn G. Hardy, Post Office Box 373, Lewiston. Secretary-Treasurer, Mrs. Pauline R. Landry, 169 South Street, Biddeford.

State Department of Health and Welfare—Edith L. Soule, Director, Division of Public Health Nursing, Augusta.

Maine Public Health Association—Theresa R. Anderson, 256 Water Street, Augusta. (As of December 1938)

State Nurses' Association Paid Executive—Mrs. Alice S. Hawes, 54 Saunders Street, Portland.

MARYLAND

State Organization for Public Health Nursing—President, Eleanor M. Immler, 31 South Calvert Street, Baltimore. Secretary, Charlotte von Briesen, 346 Rosebank Avenue, Baltimore. Treasurer, Irene Duffy, 1601 Bolton Street, Baltimore.

State Department of Health—Catherine Corley, Nurse Instructor, Division of Maternal and Child Health, Baltimore.

State Nurses' Association Paid Executive—Mrs. Blanche G. Powell, 1217 Cathedral Street, Baltimore.

MASSACHUSETTS

Massachusetts Organization for Public Health Nursing—President, Mrs. John H. Seaman, 31 Lafayette Street, Fairhaven. Secretary, Mrs. Thomas Worcester, 205 Putnam Street, Waltham. Treasurer, Helen F. McCaffrey, 20 Commonwealth Avenue, Boston. Chairman Membership Committee, Mrs. Collins Graham, 223 Slade Street, Belmont.

State Department of Public Health—(Vacant) Chief Consultant, Public Health Nursing, Division of Child Hygiene, State House, Boston.

State Nurses' Association Paid Executive—Helene G. Lee, 420 Boylston Street, Boston.

MICHIGAN

State Organization for Public Health Nursing—President, Edna L. Hamilton, 660 Frederick Street, Detroit. Secretary, Dorothy Cooper, Eaton County Health Department, Charlotte. Treasurer, May Ellen Redmond, Visiting Nurse Association, Bay City. Chairman Membership Committee, Mrs. Elizabeth Hoffman, Vassar.

State Department of Health—Helen Bean, Director, Bureau of Public Health Nursing, Lansing.

State Nurses' Association Paid Executive—Olive Sewell, Capitol Savings and Loan Building, Lansing.

MINNESOTA

State Organization for Public Health Nursing—President, Ann S. Nyquist, State Department of Health, University Campus, Minneapolis. Secretary, Ann Lindell, 1543 La Fond Street, St. Paul. Treasurer, Sanford C. Gustafson, Hopkins. Chairman Membership Committee, Emilie J. Mosford, State Department of Health, University Campus, Minneapolis.

State Department of Health—Olivia Peterson, Director, Division of Public Health Nursing, Minneapolis.

Minnesota Public Health Association—Mabel Johnson, 11 West Summit Avenue, St. Paul.

State Nurses' Association Paid Executive—Caroline Rankiellour, 2642 University Avenue, St. Paul.

MISSISSIPPI

Section on Public Health Nursing of State Nurses' Association—Chairman, O'Connor George, State Board of Health, Jackson.

State Board of Health—Mary D. Osborne, Director of Public Health Nursing, Division of County Health Service, Jackson.

MISSOURI

Section on Public Health Nursing of State Nurses' Association—Chairman, Gertrude Aufranc, 902 University, Columbia. Vice-Chairman, Mrs. Flora Jerabek, 2902 Seneca, St. Joseph. Secretary, Petronella Madden, 4250 Neosho, St. Louis.

State Board of Health—Helena A. Dunham, Director, Division of Public Health Nursing, Jefferson City.

Missouri Tuberculosis Association—Mrs. Blanche Crawford and Gene Ross, 411 North Tenth Street, St. Louis.

State Nurses' Association Paid Executive—Mary E. Stebbins, 1101 Waldheim Building, Kansas City.

MONTANA

State Organization for Public Health Nursing—President, Alice M. West, Olive Hotel, Miles City. Vice-President, Freda Miller, State Department of Public Welfare, Helena. Secretary, Helen Murphy, Court House, Butte. Treasurer, Hazel Callehan, 1930 Argyle Street, Butte.

State Board of Health—Florence V. Whipple, Supervisor of Public Health Nursing, Division of Child Hygiene, Helena.

Montana Tuberculosis Association—Henrietta Crockett, Helena.

NEBRASKA

Section on Public Health Nursing of State Nurses' Association—Chairman, Mrs. Catherine Lavelle Gehrman, Rural Free Delivery No. 5, South Omaha. Vice-Chairman, Ruth E. Simonson, 1220 South 20 Street, Lincoln. Secretary, Shirley Diamond, 611 West 27 Street, Kearney. Chairman Membership Committee, Eleanor Palmquist, 1220 South 20 Street, Lincoln.

State Department of Health—Eleanor Palmquist, Public Health Nursing Consultant, Omaha.

State Nurses' Association Paid Executive—Halcie M. Boyer, 626 Electric Building, Omaha.

NEVADA

State Board of Health—Mrs. Christie A. Thompson, State Public Health Supervising Nurse, Division of Child Hygiene, 12 Fordonia Building, Reno.

NEW HAMPSHIRE

Section on Public Health Nursing of Graduate Nurses' Association—Chairman, Bertha Hutchins, 83 Washington Street, Concord. Vice-Chairman, Marion Moynihan, 31 Franklin Street, Franklin. Secretary, Marion Blake, 25 Oak Street, Laconia.

State Board of Health—Mrs. Mary D. Davis, Director, Division of Public Health Nursing, Concord.

State Board of Education—Elizabeth M. Murphy, Supervisor of Health, Concord.

NEW JERSEY

State Organization for Public Health Nursing—President, Nellie Ogilvie, Bernardsville. Corresponding Secretary, Mrs. Lillian K. Smith, 292 Broad Street, Newark. Treasurer, Mary E. Edgcomb, Englewood Hospital, Englewood. Chairman Membership Committee, Emily Lydon, 42 Park Place, Newark.

State Department of Health—Alice Boyer, Supervisor of Nurses, Bureau of Maternal and Child Health, Trenton.

State Department of Public Instruction—Lula P. Dilworth, Associate in Health and Safety Education, 1302 Trenton Trust Company Building, Trenton.

State Nurses' Association Paid Executive—Wilkie Hughes, 17 Academy Street, Newark.

NEW MEXICO

Section on Public Health Nursing of State Nurses' Association—Acting Chairman, Ella Yeager, Educational Department, Public Schools, Dexter. Vice-Chairman, Mrs. Ruth Smith, Public Health Department, Portales. Secretary, M. Easter Flynn, Public Health Office, Bernalillo County, Albuquerque.

State Department of Public Welfare—Mrs. Fannie Tittsworth Warncke, Director of Public Health Nursing, Santa Fe.

NEW YORK

Section on Public Health Nursing of State Nurses' Association—Chairman, Bosse B. Randle, Nassau County Health Department, Bar Building, Mineola. Vice-Chairman, Ethel Phillips, Federal Building, Elmira. Secretary, Veronica Donnelly, Glenwood Apartments, The Livingston, Ravine Avenue, Yonkers.

State Department of Health—Marion W. Sheahan, Director, Division of Public Health Nursing, Albany.

State Education Department—Marie Swanson, State Supervisor of School Nursing, State Education Building, Albany.

State Nurses' Association Paid Executive—Emily J. Hicks, 152 Washington Avenue, Albany.

NORTH CAROLINA

Section on Public Health Nursing of State Nurses' Association—Chairman, Theodosia Flud, City Health Department, Fayetteville.

Vice-Chairman, Cora Beam, Shelby. Secretary, Alma Kee, Chapel Hill.

State Board of Health—(Vacant) Public Health Nursing Consultant, Division of County Health Work, Raleigh.

State Nurses' Association Paid Executive—Edna L. Heinzerling, 417 Commercial Building, Raleigh.

NORTH DAKOTA

Section on Public Health Nursing of State Nurses' Association—Chairman, Mildred Udgard, Cass County Court House, Fargo. Vice-Chairman, Esther Teichman, 500 Avenue A., Bismarck. Secretary, Florence E. Ferguson, Grafton.

State Department of Health—(Vacant) Supervisor of Public Health Nursing, State Capitol, Bismarck.

OHIO

Section on Public Health Nursing of State Nurses' Association—Chairman, Mrs. Carrie E. Lewis, Board of Health, Room 117, City Hall, Cleveland. Vice-Chairman, Retta Clark, Visiting Nurse Association, Toledo. Secretary, Mrs. Leuty N. Briese, 2906 Robinwood Avenue, Toledo.

State Department of Health—S. Gertrude Bush, Chief, Division of Public Health Nursing, Columbus.

State Nurses' Association Paid Executive—Mrs. E. P. August, 50 East Broad Street, Columbus.

OKLAHOMA

State Organization for Public Health Nursing—President, Bess Killough, Hobart. Secretary, Grace Baldwin, 502 North Main, Elk City. Treasurer, Jessie Younger, Box 821, Wewoka. Chairman Membership Committee, Laura Van de Mark, State Department of Health, Oklahoma City.

State Department of Public Health—Josephine Daniel, Director, Public Health Nursing, Oklahoma City.

OREGON

State Organization for Public Health Nursing—President, Mrs. Catherine Webster, 2825 Northeast 35 Place, Portland. Secretary, Aileen Dyer, 1206 Southwest Gibbs Street, Portland. Treasurer, Mrs. Hazel Foeller, 2255 Southeast Spruce, Portland. Chairman Membership Committee, Olive Whitlock, 816 Oregon Building, Portland.

State Board of Health—Lucile Perozzi, Director, Division of Public Health Nursing, 816 Oregon Building, Portland.

State Nurses' Association Paid Executive—Mrs. Linnie Laird, 301 Stevens Building, Portland.

PENNSYLVANIA

State Organization for Public Health Nursing—President, Mathilda Scheuer, 1340 Lombard Street, Philadelphia. Secretary, F. Mabel Bucks, 347 Spring Street, Reading. Treasurer, Helen V. Stevens, 519 Smithfield Street, Pittsburgh. Chairman Membership Committee, Vesta Miller, Visiting Nurse Association, Lancaster.

State Department of Health—Alice M. O'Halloran, Director, Bureau of Public Health Nursing, Harrisburg.

State Department of Public Instruction—Mrs. Lois L. Owen, School Nursing Adviser, Harrisburg.

Pennsylvania Tuberculosis Society—Frances H. Meyer, 311 South Juniper Street, Philadelphia.

State Nurses' Association Paid Executive—Esther R. Entriiken, 400 North Third Street, Harrisburg.

RHODE ISLAND

State Organization for Public Health Nursing—President, Mary C. Mulvany, Health Department, City Hall, Providence. Secretary, Flor-

ence Little, 261 County Road, Barrington. Treasurer, Agnes Nestor, 710 North Main Street, Providence. Chairman Membership Committee, Ruth C. M. Anderson, 30 Rolfe Street, Cranston.

State Department of Health—Bertha E. Jutras, Public Health Nursing Consultant, Division of Administration, Providence.

State Nurses' Association Paid Executive—Annie M. Earley, 381 Angell Street, Providence.

SOUTH CAROLINA

Public Health Nursing Section of State Nurses' Association—Chairman, Idalia Padgett, County Health Department, Walterboro. First Vice-Chairman, Catherine Ramsey, State Board of Health, Columbia. Secretary, Elizabeth Clayton, State Board of Health, Columbia.

State Board of Health—Mrs. Ruth George, Public Health Nursing Consultant, Division of County Health Work, Columbia.

State Nurses' Association Paid Executive—Nellie C. Cunningham, 306 Carolina Life Building, Columbia.

SOUTH DAKOTA

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PUBLIC HEALTH NURSING

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"YOU ARE OLD, FATHER WILLIAM . . ."

PUBLIC HEALTH NURSING is growing older. It has in fact reached middle age in the United States, and before long some ambitious scholar in our field will come to the N.O.P.H.N. and ask, "Where can I get original records and source material concerning the early development of public health nursing? I am writing the history of public health nursing in the United States."

Some years ago Ada M. Carr, the former editor of PUBLIC HEALTH NURSING magazine, urged in her farsighted way that the National Organization for Public Health Nursing set aside a historical file into which our own past records might go, together with any other material of national significance. Thanks to her, a very meager beginning has been made for the preservation of important N.O.P.H.N. papers. The recent death of our first director, Ella Phillips Crandall, reminded us of the need for the collection of data of historical value in all phases of our work. And an S.O.P.H.N. project dealing with the history of public health nursing in New Jersey called attention anew to this growing need.

It seems to the N.O.P.H.N. that several important steps should be taken by public health nursing agencies. First, may we urge you to keep a historical file—containing, for instance, one set of sample record forms, copies of letters

that mark significant changes in your program or basic policies, the minutes of your board, financial statements, yearly reports, possibly some committee reports, and pictures. One agency that we know is to be envied in having a sample of each uniform worn by the staff in the last thirty years and a precious old bag.

Second, if you have valuable letters or papers that deal with your state situation, see that they find their way to a permanent state file or state archives where they can be used by future students and historians. State or college libraries may be interested if the material is truly original, unique, and valuable.

Third, if you have letters, papers, reports, programs of meetings, or pictures which have reference to N.O.P.H.N. activities or nationwide changes in public health nursing, may we hear about them so that we may know where to find them. Or, in case you cannot store them longer, may we have the chance to add them to our historical folder if they are not duplicates. Perhaps some of us as individuals have letters that show changing trends, attitudes, or customs. Let these be saved somewhere!

If you have this eye to the future, someone some day will rise up and call you blessed.

D.D.

GIVE US AIR!

"DON'T BOTHER about the ventilation. This is a health meeting," remarked a committee member humorously at a recent half-day committee session.

Who has not had the experience of suffocating in an air-tight room at 85 degrees temperature for a three-hour meeting; or, more rarely, of sitting wrapped in coats while toes and fingers get colder by the minute. True, psychological experiments show that when interest is sufficiently keen, external discomforts are forgotten. Nevertheless, the strongest enthusiasm is apt to lag sometime during a long meeting. Comfortable external conditions are certainly conducive to sustained attention and effective participation—to say nothing of optimal health.

An overheated, stuffy room is perhaps to be expected at a political meeting or a business meeting—anything but a health meeting. But the fact that health meetings are so frequently planned without any consideration of physical factors is an example of our failure to practice what we teach, which in turn is one of the reasons for failures in the effectiveness of our teaching.

Of course it is hard to make everyone comfortable. Some rooms have such poor ventilating facilities that those near the windows will be cold if there is enough circulation of air to penetrate to the far corners of the room. Moreover, people differ in their needs as to temperature—although there is not a great range of difference in the temperatures that are favorable to health. Again, people may be dressed in clothes of varying warmth. Mrs. Smith ventures out in her spring suit while Miss Brown has her winter coat to throw over her shoulders if necessary. And people's reaction to heat and cold varies. It is different for different people and at

different times. Mr. Frail who is just recovering from bronchitis is especially sensitive to drafts while vigorous Mr. Frost can sit in a gale and like it.

How can all these factors be reconciled? First of all, the meeting place can be chosen with the greatest possible consideration for comfort. In many localities there is no choice, but often there are possible alternatives. Rooms which have artificial ventilation systems and no windows sometimes become insufferably close in the course of a two-hour meeting. The provision of electric fans in advance may mean the difference between a successful meeting and an exhausted audience that can hardly wait for the session to close.

Whatever the ventilation facilities, we suggest that a person appointed in advance be made responsible for seeing that the temperature and circulation of air are kept as comfortable as possible. At least one room thermometer should be brought to the meeting if none is there already. The ventilation monitor may then consult the thermometer at 30-minute intervals, moving it unobtrusively around the room as necessary to make sure that the temperature in all parts remains around 70° F. The windows may be opened for short periods as necessary to insure periodic circulation of air. And if necessary people near the windows who are sensitive to cold may be helped to find seats elsewhere. If the session is over two hours, a five-minute recess with windows open while everyone stands will yield surprising returns in the attention and interest of the group during the last hour.

For a belated New Year's resolution, we suggest that definite plans be made for the proper temperature and ventilation of the room at all health meetings.

Dynamic Relationships

By EDWARD S. GODFREY, JR., M.D.

The relationship of the state division of public health nursing to local agencies—public and private—is discussed by the health commissioner of New York State

MUCH HAS been said about the relationship of the state divisions of public health nursing to local agencies. While the mechanics can be discussed in terms of nursing, the fundamentals are broader. They are contained, on the one hand, in the essential differences between the agencies concerned, and on the other, in the relatedness of their goals. It hardly need be said that dynamic relationships intended to form a workable base for the conduct of a coördinated community health service must not be left to chance. The connections should be tangible and kept alive through use. Stripped of the polite exchanges of appreciation for the existence and work of each other, I believe this subject of agency relationships can be discussed from the point of view of good administrative practice. Certainly, the task of administration is so to utilize the various parts of associated agencies that they are organized to operate effectively and economically to accomplish the purpose for which they exist.

The nature of a health service strikes at the roots of living; therefore, it must of necessity take into account the complexities of modern communal life. The social factors are equal in importance to the medical factors if the findings of medicine are to be placed at the disposal of the people. Not among the least of the social factors in relation to a health program for all the people are those which have produced widespread citizen effort to meet human needs as distin-

guished from governmental effort through state and local units. An understanding of the underlying principles of public and private organized effort would appear to simplify the problem and at the same time establish the permanency of these channels of expression through which we help ourselves toward a better life. The current programs of each agency will of necessity change, but agencies as types of community endeavor will find newer and more effective channels through which to express themselves.

Voluntary agencies should exist only so long as they serve a useful purpose which is not fulfilled adequately by government. If the services overlap through failure to understand and to be alert to the necessity for the changes which indicate growth instead of stagnation, then the agency is obstructing progress and by the very forces which govern us must go or be altered. If the agency be private it will in time die a natural death; if it be public the will of the people will express itself in new laws or officials more truly representing majority opinion.

It may be necessary to make clear the concepts of public and private agencies—as distinguished from each other—upon which the above observations are based.

PRIVATE AGENCY CHARACTERISTICS

The private or unofficial agency has its inception in the initiative of a group of citizens whose concern for certain human needs causes them to establish an organization to meet those needs. It

is the expression of the right of citizens to perform certain functions on a personal basis without waiting for the consent of the whole body of people. If the need be widespread, affecting a large group of people, the public becomes educated to the service and accepts it as a right. The work then becomes a natural public function. This appears to be a logical and inevitable process, in the light of our traditions. This method of educating the public is an expression of democracy at work. The opinions of a minority find expression, but cannot safely be imposed upon the majority until they are ready to accept them.

Linton B. Swift in his clarifying discussion of this subject states in part: "The private agency should endeavor to increase the minority gradually through educational methods; but the rapid creation of a majority supporting constituency, before public understanding of specific services has matured, merely gives the private agency one of the characteristics of a public agency without the latter's accompanying strengths."* Mr. Swift further points out that to fulfill its purpose the private agency "should seek not to duplicate but to supplement the work of the public agency, through

"1. Performing services that may not be properly a function of government or are clearly not yet acceptable to majority public opinion.

"2. Meeting limitations that are not necessarily inherent in a public agency but may be imposed by law or custom.

"3. Emphasizing innovation and variety rather than uniformity of method."**

Mr. Swift convincingly places the private agency in juxtaposition to the public agency, with the former's program by its very nature supplementary to the

latter. A review of the essential characteristics of a public agency may serve to further elucidate this point.

PUBLIC AGENCY CHARACTERISTICS

A public agency is one which is established by law. It is administered by officials who are in fact the representatives of the people. Some of its functions are defined by law; others are the opinions and judgments of the officials who interpret their duties and prerogatives under the law. They are nonetheless an expression of majority opinion of the people who technically and legally endorse the lawmakers and the officials who function in governmental departments. These functions must therefore have reached a point to be accepted by the majority, before they will be provided by a public agency. The public agency cannot in the long run go far beyond or lag far behind the level of general public understanding. Also, as an instrument of government its functions must be related to and frequently limited by other departments of government. Inherent in public agency programs are functions which require the resources of the community and the authority of government.

STATE SUPERVISION OF LOCAL UNIT

According to James A. Tobey,* in his summary of Public Health Law, the amount of control that can be exercised by state health departments over local health officials and local health conditions is governed by the statutes in each individual state. In some states, this control is extensive, local health officers being appointed by the state health department, or such appointments being subject to the approval of state health authorities. In other states, the state health department has some control over county health officers but little jurisdiction over municipal health officials,

*Swift, Linton. *New Alignments Between Public and Private Agencies in a Community*. Family Welfare Association of America, New York, 1934, p. 13.

***Ibid.*

*Tobey, James. *Public Health Law*. The Commonwealth Fund, New York, 1939, p. 71.

although the department usually can intervene in local affairs in times of emergency, epidemics, or when the health of the people of a considerable part of the state is in jeopardy. In some larger cities, such as New York and Baltimore, municipal charters granted by the state have given to the local health authorities complete or virtually complete control over the public health of the city.

After pointing out these variations in state situations, Tobey gives the general consensus among experts in public health as follows: "Whatever may be the terms of the law, it seems agreed among experts on public health that the state health department should assume leadership in the public health affairs of the state." "This department," he adds, "should offer guidance to local authorities at all times, and exert actual control when conditions warrant such action."** This, to my mind, constitutes an adequate common denominator which makes it possible to offer more specific discussion of the topic of this address.

The assumption of this leadership over the public health affairs of the state by the state health department presupposes a cognizance of the work of private agencies in order that their potential strengths may be utilized intelligently in the interest of the health program. Applying this to nursing, I would make no distinction—in the responsibility of a state nursing division for leadership—between local agencies, be they public or private. I would, however, see the relationship expressed in different ways in accordance with the characteristics of each type of service.

The demands of the moment may mean that the private agency may be most useful by continuing to carry or by assuming certain nursing functions even though they have become accepted as public functions and are ready to be transferred when the stage is set. There-

fore, it is not possible to generalize about what specific agencies should do at any given time, nor what specific assistance might be appropriate from the state. An interchange of functions will do no harm if the reasons are understood and are justifiable. This presupposes a clear understanding of the ultimate goals and an appreciation of the inherent differences between public and private endeavor. Even though the public agency takes precedence by its very nature, neither type of agency is more important in function, since each has its separate values.

BROADER LOYALTY NEEDED

An important step in state leadership, therefore, should be to understand and interpret the fundamentals of both the public and private agency so that each feels secure because of its true and separate values. This should produce a loyalty which is broader than a single agency loyalty and will be much less apt to limit the usefulness of the agency through placing it out of line in the procession. A purposeful and continuous effort to bring about such comprehension will tend to encourage objectivity on the part of the individuals who make up state and local agencies. After all, it is the habits of thought of individuals and their subsequent expression in action which determine the quality of the agency they represent. An approach to problems and programs on these broad principles will remove the possibility of refusal to give way or to assume one's appropriate and changing place in this joint project of community health.

The second step in state leadership would be to take a part in stimulating and analyzing existing local programs to the end that nursing becomes increasingly effective. This would indicate an awareness of all agencies that have a right to be considered, and the allocation to each of the work which is characteristic to it. It would imply a definition

***Ibid.*

by the state agency of those functions which have become, by value of acceptance, a recognized public function.

WHO SHALL DO BEDSIDE NURSING

Bedside nursing, available on a fee basis or free to those in need, is an example of service which has been for years rendered by private agencies. It has been considered a recognized function of the private agency. Changing economic conditions have gradually split this function. Payment to the private agency by the public agency for the care of indigents is now accepted as a function of government. Rules and regulations of the welfare departments which state the basis for payment is evidence of that acceptance of responsibility by the state. While some communities lag behind the state, for the most part the state pattern soon becomes a guide for local governmental units.

There are still some differences of opinion regarding the method of providing a visiting bedside nursing service for all the people in every hamlet of the state. There seems to be an acceptance by the public that they need the service. If they endorse it to the extent of providing funds for that purpose, then the service becomes a proper one to the public agency. The judgment of the leaders would then be necessary to determine, with an eye to the fundamentals, whether or not the private agency might become the agent of the public, at least until public support had become stable. It is within the extent of state leadership to be equally concerned for the place of both public and private agencies, helping each to assume its proper functions in the most effective manner. If in the process a private agency is encouraged to disband or assume new functions, or a new one to be organized, the criteria by which to judge the appropriateness of such action should be found through analyzing the inherent functions. In the long run if our premises are accurate, they will be understood.

Without attempting to go into detail as to the specific instruments which are useful in exerting leadership, I would call attention to the degrees of responsibility for improving the practice of local nursing service rendered by the two agencies—public and private. The state determines the general health functions of government; therefore broad state programs and policies set a pattern for local government units. The influence of the federal program must not be forgotten in this respect. It is fitting, therefore, that the state's help to local public units be in the nature of providing standards for programs, outlining qualifications of personnel, developing guides such as records and manuals, and establishing supervisory service to improve practice with the intent—no matter how democratically expressed—of holding the local department to account for its actions. The extent of state leadership for local public units must of necessity aim to go just as far as the local situations warrant, determined of course by personnel limitations.

If the private agency is rendering a public health nursing service, functioning within its proper scope, it should be offered all the available aids it wishes to accept; but every effort should be made to leave it free and unhampered to experiment in new fields and to develop new methods.

These observations are intended to indicate the scope of the relationship of the state division of public health nursing to local services. The every day details of making the relationship work are intrusted to the agencies concerned. It is no small part of the success of our whole program. I would suggest to the representatives of private agencies that they take initiative in counseling with the state officials, thereby making the leadership a truly reciprocal connection.

Presented before the Public Health Nursing Section, The Sixty-Eighth Annual Meeting of the American Public Health Association, Pittsburgh, Pennsylvania, October 17, 1939.

Rheumatoid Arthritis

By T. LLOYD TYSON, M.D.

The social and economic significance of arthritis as a cause of disability is increasingly recognized. This is the first of two articles on this important problem

THE TERM *arthritis* embraces such a vast field that any short discussion of the subject must of necessity be limited in scope. Most cases fall into the two great groups of rheumatoid arthritis (atrophic, chronic infections) and osteo (degenerative, hypertrophic) arthritis.

Before discussing rheumatoid arthritis it should be emphasized that the term *chronic arthritis* is a broad one, embracing a large group of separate clinical entities due to different causes, but all having a common tendency to involve the joints in a chronic process.

Only lately the social and economic importance of chronic arthritis has been recognized, chiefly because the medical profession has remained indifferent to the problem until recently because, as a rule, it does not shorten life and is not communicable. Chronic arthritis is now recognized as the greatest single cause of disability in temperate climates, with the possible exception of cardiovascular disease. A report of the Welfare Council of New York City indicates that chronic arthritis is a more serious cause of suffering and economic loss than any other chronic disease.¹

DIFFERENTIATION BETWEEN TYPES

Since this article and the succeeding one are limited to a discussion of rheumatoid and osteo arthritis, it would be well to differentiate between these two types. Rheumatoid arthritis is a chronic, systemic infection of unknown cause, usually affecting young adults, although it

may occur at any age. It causes severe pain, swelling, and stiffening of the joints, and wasting of the tissues. In severe cases it may cripple the patient for life by stiffening and deforming the extremities.

Osteo arthritis, on the other hand, is not an infection but a result of the wear and tear of the years. Usually, it affects the weight-bearing joints, whereas rheumatoid arthritis may and does affect any joint. Osteo arthritis never affects the young and usually causes pain only when the joints are being used. Complete stiffening of the joints never occurs and as a rule the disease causes more annoyance and discomfort than real disability.

RHEUMATOID ARTHRITIS

Because of these differences, rheumatoid arthritis presents the greater problem. Although its actual cause is unknown, certain facts pertaining to it are definite. The geographic distribution of rheumatoid arthritis is interesting and has been known for years. Like rheumatic fever, it is a disease primarily of the temperate zones and its incidence decreases rapidly as one approaches the equator. The significance of this is not clear but it is suspected that it may be linked with the geographic distribution of the hemolytic streptococcus, which is roughly similar.

The familial incidence of rheumatoid arthritis is not striking, but various workers have observed that it has a definite tendency to affect more than one

member of the same family. Figures from different sources indicate that in from 14 to 20 percent of cases there is a history of another member of the family being affected.

WOMEN MORE SUSCEPTIBLE

The sex incidence of the disease is striking and authorities agree that females are afflicted three times as often as males. The predominance of the liability of females to the disease is not understood. There is one exception to this rule, however, and that is rheumatoid arthritis limited solely to the spine, known as "poker spine," or Marie-Strumpell spondylitis. This disease is ten times as common in males as in females.

In most cases the age of onset of rheumatoid arthritis is between 25 and 40 and reaches its peak at 35. This fact is surprising to many and is one of the reasons the disease is such a distressing problem, since it affects people in their most useful years. Osteo arthritis, on the other hand, is a disease of the later decades and is seldom met with under 50. Rarely, rheumatoid arthritis may occur in the seventies, and it may affect children in the form known as Still's disease.

The seasonal influence on this disease is interesting. In a chronic disease it is sometimes difficult to ascertain the time of onset, but in spite of this fact it has been observed that the majority of cases of rheumatoid arthritis begin in the spring months of the year. Most patients experience their greatest discomfort at this time and are relatively free from symptoms in the late summer and early fall.

FACTOR OF INFECTION

The factor of infection in rheumatoid arthritis is one that has aroused a good deal of controversy, but most authorities now agree that this disease is definitely a chronic infection, although the exact

cause is unknown. Recently serologic evidence has been accumulated to support this hypothesis. The high sedimentation rates and the positive agglutinations with the hemolytic streptococcus found in the blood of some of these patients are points in this favor. However, no one has been able as yet to isolate any germ from the blood or joints of patients with rheumatoid arthritis.

The significance of focal infection remains one of the most controversial points in the study of this disease. During the past twenty years there has developed in American medicine a general impression that most cases of rheumatoid arthritis are attributable to infected teeth, tonsils, sinuses, or other foci. Continental and British physicians, on the other hand, have accepted this theory less favorably, and even in this country not a few observers have maintained an attitude of scepticism on this point. Much that has been written about the beneficial effect on the disease resulting from the removal of infected foci is not critical and not controlled. A very recent series of similar cases, half of which had foci removed and half of which did not, showed no appreciable difference in the course of the disease after a year.² Another objection to this hypothesis is the fact that many cases do not have infected foci.

On the other hand, the importance of this theory may not be too lightly passed over, for too many cases do begin following an infection of the upper respiratory tract. It may be that this serves as a portal of entry; but once the disease is established, removing a focus does not seem to alter the course of it. The present consensus of the best opinions in this field is that the upper respiratory tract may play an important role in the onset of the disease; hence any obviously infected foci should be removed as a general health measure. But specific therapeutic results cannot be expected from removing such foci, and to remove

teeth, tonsils, appendices, or gall bladders indiscriminately is not only unwise but inhuman.

SYMPTOMS

The symptomatology of rheumatoid arthritis is variable in onset and character and may be acute or insidious. Some cases begin with acute, painful, swollen joints which are differentiated from those of acute rheumatic fever only with great difficulty. The majority of cases, however, begin more insidiously with mild, recurrent, moderately painful swellings which slowly progress in severity and number until eventually most joints are involved by the process. Frequently, along with the involvement of the joints there are constitutional symptoms such as slight fever, rapid pulse, loss of weight and strength, anemia, and easy fatigability. The small joints of the extremities, particularly those of the fingers and toes, are very prone to be affected first; while later the larger joints such as those of the knees, wrists, elbows, shoulders, and hips are apt to become involved. The characteristic swelling about the joints is due to inflammation of soft tissue rather than bony enlargement and is accompanied in most instances by marked muscle wasting and weakness. Gastro-intestinal symptoms and cardiac involvement occur as complications only rarely, while iritis and enlargement of the lymph glands are not uncommon.

TREATMENT

The treatment of rheumatoid arthritis has provoked a good deal of controversy, mainly because there is no one specific drug nor measure which produces a cure. As a result the number of therapeutic suggestions is infinite, each heralded as the best by its own proposer or sponsor. Out of this melee, however, experience has shown certain measures to have value in the treatment of rheumatoid arthritis.

Since the disease is an infection of

unknown etiology, all observers agree that the most important measures are those directed toward the support of the patient. As in tuberculosis and other infections, *rest* is the most effective therapeutic agent we have. In rheumatoid arthritis, however, it is doubly important because rest is needed not only for the body but for the involved joints as well.

In the acute stage patients should be kept in bed as much as possible. During this period, once or twice daily, the joints should be put through as full a range of motion as is possible without pain, to prevent stiffening. While at rest the joints should be kept in their normal physiological positions to prevent contractures from forming. This is accomplished by putting the joints in suitable splints which, when properly applied, give immediate relief. These splints should be removable so that the joints can be put through the gentle, daily motions necessary to prevent the formation of adhesions. As the acuteness subsides, the joints can be put through greater ranges of motion more frequently, but always gently and with a minimum of pain. If this type of therapy were followed in every case, all deformities could be prevented, which is the main objective in treatment.

Those who have deformities when first seen should have similar care. After the disease becomes inactive, adhesions may be broken down by manipulation under light anesthesia, or operative procedures may free ankylosed joints.

In addition to rest, other important measures are adequate sleep, fresh air, sunshine, and freedom from worry.

The removal of foci of infection has been discussed previously and all obviously diseased foci should be treated, but with a conservative attitude. The wholesale removal of questionable teeth is to be condemned particularly, as their relation to this disease is becoming less and less accepted.

The effect of climate on the disease has been widely discussed and it is agreed generally that patients do better in a warm, equable climate such as that of Florida, or even better, the tropics.

Injections of various types have been used extensively in the treatment of rheumatoid arthritis but with conflicting results. The intravenous and subcutaneous injections of vaccines of various kinds probably have been more widely used than any other type of therapy. These include autogenous vaccines, streptococcal vaccines, and typhoid fever vaccines. But after ten to fifteen years' trial, it is being accepted more and more generally that none of these has any beneficial effect other than a psychological one. In a control series of patients receiving plain saline solution the results were just as good as in patients who were receiving vaccines.³ The same may be said for injections of colloidal sulphur.

Much has been written of the effect of various diets on the disease. As long ago as 1910, Garrod stated that nothing is gained whereas much may be lost by restrictions in the diet of patients, with the exception of course of dietary restrictions imposed by a constitutional condition such as diabetes.⁴ It is now general practice to give patients a diet high in vitamins and calories, with no restrictions except in cases where weight reduction is desirable.

Of all the different drugs recommended at one time or another for rheumatoid arthritis, only three have stood

the test of time. Salicylates remain the most important and least dangerous in controlling pain, but have no effect on the actual course of the disease. Cod-liver oil and iron, in liberal doses, are beneficial in supportive treatment and over a period of time do a great deal in preventing loss of weight and anemia. The only other drug which has shown promise of being useful is gold in the form of a soluble salt. This is given intramuscularly or intravenously and the recent literature on it is quite promising. Until further reports are available, however, it should not be used excepting where the patients can be followed carefully, for it has the disadvantage of causing toxic reactions.

In addition to the above methods of care, physical therapy offers a real aid in the alleviation of pain and prevention of deformities. It should never be strenuous enough to fatigue or exhaust the patient. Hydrotherapy is particularly valuable as it allows gentle motion, without muscle strain, in a buoyant medium.

It should be emphasized that rheumatoid arthritis is in most cases a disease which can be helped a good deal, and in a not inconsiderable number of cases, cured. There is, however, no specific drug and it is only by constant, persevering work on the part of the patient, nurse, and physician that this result may be accomplished.

An article on osteo arthritis, by Dr. C. R. Wise, will appear in the March issue.

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An Orthopedic Service in the Rockies

By IONE COYLE, R.N.

A rural frontier state in the Far West develops a service for its crippled children in the face of tremendous handicaps of distance, transportation, and lack of resources

ADEQUATE orthopedic care for Idaho's crippled children presents a challenge to the public health nurse and her co-workers which perhaps has no parallel in the United States. Some of the reasons for its uniqueness is traced to the physical characteristics and the early history of this little-known state.

LAST FRONTIER

Idaho has been called "America's last frontier." Its eighty-four thousand square miles of territory include a vast unspoiled portion of the Old West. There are primitive stretches of isolated wilderness in the mountainous regions of the Bitter Root, Sawtooth, and other Rocky Mountain ranges. There are peaks capped with perpetual snow which tower above canyons and gorges said never to have been penetrated by white men. Idaho has grassy mountain meadows for grazing flocks and herds, dense virgin forests of pine and fir, and thousands of miles of sage-carpeted desert. It has also the Snake River, a mighty stream which takes a serpentine course across the state and provides much of its western boundary. The valley of the Snake forms a broad belt of irrigated land which is one of the most richly productive agricultural and fruit-growing areas in the United States. But most of Idaho is rugged and untamed, a land of natural grandeur whose scenic beauty rivals that of the Canadian Rockies and the Swiss Alps.

In size, Idaho equals the combined areas of a group of six states of the

Atlantic seaboard—New York, New Jersey, Maryland, Massachusetts, Rhode Island, and Connecticut. Idaho borders half a dozen states and the Dominion of Canada. The distance across the southern part of the state is more than four hundred miles by highway; the driving distance from the Nevada boundary north to the Canadian border is almost seven hundred miles. While there are several superb arterial highways which facilitate travel, many of the side roads are extremely rough and unbelievably narrow and winding, with numerous precipitous mountain grades that are snowlocked for months each year. Some localities are accessible only by snowshoe or horseback in winter.

The climate is as rugged as the country. The summers are unusually hot and dry in most sections. Subzero temperatures are usual in winter, while in certain areas temperatures of forty degrees below zero are common. In a few communities schools close for the year at Christmas recess, reopening the following July because of the impossibility of travel during the winter months.

A YOUNG STATE

Idaho's history suggests other causes for some of its present problems. While Lewis and Clark explored the region more than a century and a quarter ago, settlers began coming in appreciable numbers only after gold was discovered in 1860. Idaho is essentially young. The country has defied settlement and most of it has emerged from the condition of an inaccessible wilderness in



A cabin on the "last frontier"

somewhat less than thirty years. During this period the population has almost trebled, although the last census shows a total of only four hundred and fifty thousand persons.

Idaho's villages and hamlets are isolated; its cities few and scattered. In fact, census figures show only two cities of over ten thousand population. Boise, the capital and largest city, reported less than twenty-two thousand population. Idaho may be considered a completely rural state. However, its rapid growth is continuing, and the 1940 census is expected to reveal an appreciable increase in population. The State's birth rate is one of the highest in the United States. It has a young population, constantly augmented by groups of young people from the East and Midwest, driven from their homes and farms by drought, dust, and overcrowding. These people are turning their faces westward, coming often empty-handed, to seek a new beginning on this last frontier.

Idaho is young in its establishment of various public services. The sparse pop-

ulation, the vast distances, and the inaccessibility of many towns have tended to retard progress. Public health services are very recent in development. Idaho had no official state health agency until 1937, when the Federal Social Security Act made funds available for this purpose. Likewise, there was no public agency interested in the care of crippled children. Some of the children whose parents had limited economic resources were cared for in other states at fraternal and church hospitals, but in most instances crippled children were forced to accept their handicaps. Children of means were taken to large cities outside the state because there was no orthopedic surgeon in Idaho. The first qualified specialist to practice orthopedics began his work in the state in 1936.

A CRIPPLED CHILDREN'S SERVICE

The tremendous need for adequate orthopedic care for Idaho's children had long been recognized. As soon as possible after funds became available under the Social Security Act, a Crippled Chil-

dren's Service was inaugurated; beginning in 1937 it functioned in the Division of Public Health, Department of Public Welfare.

In planning the service, consideration was given to general health facilities available throughout the state. Resources, both public and private, proved distressingly limited. Unfortunately they have changed little since that time. Several counties have no registered physician in residence for months or even years at a time. The vastness of the area and the absence of concentrated centers of population have made it almost impossible for people to have adequate medical attention and it is not uncommon for families to go fifty to a hundred miles or more for a doctor's care. The consultation of specialists is an unheard of luxury except in several of the larger cities of the state. There are few hospitals, and only two have over a hundred beds.

Due to the inadequacy of local health facilities throughout the state, the Crippled Children's Service was organized as a centralized service with headquarters in Boise, the largest city. The only qualified orthopedic surgeon in the state practices there. His services were procured as well as those of a qualified plastic surgeon, a pediatrician, and a capable brace maker. Suitable hospital facilities were obtained in the city.

ADMINISTRATIVE SET-UP

The personnel who serve on a full-time basis include a director, who is a physician having an orthopedic and a pediatric background; his assistant, who is a medical social worker; two orthopedic nurses; and a certificated physical therapist. Both nurses—who serve as state advisory nurses—hold public health nursing certificates and have had special orthopedic preparation. The part-time personnel include three specialists—an orthopedist, a pediatrician, and a plastic surgeon. All members of the Crippled Children's Service meet the

standards recommended by the United States Children's Bureau, the federal agency with which the state cooperates in carrying out the provisions of Title V Part 2 of the Social Security Act. Additional services include provision for hospital care of patients in thirty beds which are constantly available in the pediatric wings of two local hospitals—an equal number in each institution—and foster home care for convalescents when needed. These homes are supervised by a trained child welfare worker from the Division of Public Assistance.

OBJECTIVES OF THE SERVICE

The Crippled Children's Service aims to assure to every physically handicapped child in the State the development of his physical, emotional, and vocational potentialities to the maximum degree of which he is capable, with the anticipation that he may live a normal, useful life and become an asset rather than a liability to his community. To achieve this goal the Service attempts to locate and register every crippled child residing in the State. It endeavors to see that each child is under adequate medical or surgical supervision through the provision of skilled diagnostic service by a qualified surgeon at state clinics held periodically in centers which are accessible to all parts of the state and by the provision of treatment to correct crippling conditions in children whose families are not financially able to provide such care. The Service also strives to achieve its objective by cooperating with other agencies which can arrange for the education or vocational training of handicapped children. It cooperates with professional groups and public and private agencies to obtain various services such as nursing care, physical therapy, foster home care, and social services for crippled children in their own communities. The Service aims to prevent the occurrence of crippling conditions by continuous case-finding and early diag-



Across the footbridge to a rural shack

nosis of preventable conditions, and by continuous education of the public.

HOW THE PROGRAM WAS STARTED

At the inception of the program in 1936, the first effort to attain these objectives was the inauguration of an intensive case-finding program. Local surveys were made in every county. Lay and professional groups and individuals such as parent-teacher associations, clubs, nurses, social workers, and teachers made a house-to-house canvass to interest parents of crippled children in bringing them to diagnostic clinics. These clinics were held at twelve centers throughout the state. Extensive newspaper publicity also aided in increasing attendance. Since June 1936, 1971 children under twenty-one years of age have been examined by the orthopedic specialist, and 808 children have been treated, including 392 who have been hospitalized.

HOW THE SERVICE OPERATES

The Crippled Children's Service maintains a register or card catalogue of every crippled child in Idaho. Continuous case-finding is stimulated in each county,

and the names of new patients are constantly being reported. Every effort is made to keep this register accurate and up to date. After a crippled child has been reported and it is known that he is not under care, there are three major services provided for his assistance—diagnostic, treatment, and aftercare services.

Diagnostic service is provided at the clinics which are held twice a year in at least seven centers of the state. These clinics are sponsored by local communities and are planned and arranged by local health units or lay committees. Local persons are responsible for the physical set-up of the clinic, intensive case-finding, transportation of patients, and local publicity. The orthopedic specialist, the medical social worker, the physical therapist, and the orthopedic nurse attend the clinic to provide professional services for diagnosis and treatment.

Treatment service includes medical and surgical care and physical therapy in the hospitals in Boise; the provision of braces and appliances as needed; recreation for children in hospitals, under the supervision of the Junior League;

and the tutoring of hospitalized school children by junior college students under the National Youth Administration.

Aftercare services are provided through home visits by the public health nurses; check-ups by the orthopedic specialist and physical therapist at clinics; and services provided by workers in various community organizations to whom certain problems have been referred.

Public health nursing service is provided in the nine counties which have full-time health services. These counties are incorporated into four health units staffed by full-time, well qualified personnel. The public health nurses in these units carry a generalized service and include the supervision of orthopedic patients in their program. They use a special orthopedic record for recording their home visits and file it in the regular family folder, which is kept in the unit office. The nurses also make a narrative report of each visit to a crippled child, which is sent to the Crippled Children's Service to be filed in the permanent case folder. Copies of clinic findings, of hos-

pital records, and of the doctor's discharge report and orders for aftercare are sent from the state office to the units in order that each nurse may be fully aware of the progress of her orthopedic patient when he is away for treatment.

ORTHOPEDIC ADVISORY NURSES

One orthopedic advisory nurse acts as a consultant to the local and state public health personnel, in regard to orthopedic nursing problems. She is responsible for adequate public health nursing service to crippled children throughout the state. She conducts an active program of staff education for the nurses in the units. She makes contacts with these nurses at least quarterly, and spends several weeks visiting orthopedic patients with each staff nurse. She conducts classes, leads discussions, and gives demonstrations of techniques of orthopedic care needed for home instruction of mothers of crippled children. Mimeographed lesson outlines with reference bibliographies are sent to each unit several weeks in advance of the visit of the advisory nurse so that the staff nurses

Modern cave dwellers



can enter into the conference discussions with more understanding. Student nurses, graduate nurses from local organizations and from nearby counties, social workers, and any interested individuals are invited to attend these educational conferences. Interest is increasing rapidly and the attendance has doubled.

Thirty-five counties—of the forty-four—in Idaho, in which two thirds of the population reside, have no organized public health nursing services. The only health officers available are the full- or part-time county physicians. A small number have graduate nurses—most of whom have had no public health training—working in the county or the schools.

Such counties cannot provide adequate aftercare services for crippled children. The second orthopedic nurse works in these places. She spends three-quarters of her time in the field, traveling over a wide area. She instructs families in orthopedic care in the home, supervises exercises, inspects orthopedic appliances, and provides a generalized health teaching service for all members of the family. She makes numerous contacts in local communities. She becomes acquainted with local physicians, relief organizations, social workers, public school officials and teachers, influential lay individuals and leaders of civic, religious, and fraternal organizations in each of the counties. She endeavors to interest these persons in public health service for their communities and to acquaint them with the state services provided for crippled children. In this way she stimulates continuous case-finding.

VOCATIONAL REHABILITATION

Aftercare service also includes referral of patients to child welfare workers and others for assistance with social, emotional, and economic problems that affect the crippled child. All children over sixteen years of age who may be benefited are referred to the State Voca-

tional Rehabilitation Division of the Department of Education for vocational guidance and assistance. Many of the children treated surgically have profited by this vocational assistance. Fred, an adolescent boy, is an example of the possibilities of rehabilitation of the crippled child.

Fred had poliomyelitis before he was five. The result was a badly deformed foot and ankle. Supersensitive about this deformity, he grew up to be a shy, withdrawn, unfriendly appearing boy. In his early childhood the family lived on a farm which was almost inaccessible. His parents recognized the need for a specialist's care but they never found time or money to attempt the difficult, expensive journey "outside" to a city five hundred miles away, in another state.

Fred's father died when he was thirteen. The family moved to town but there was no money for a trip to a city or a specialist's examination. Fred seemed to become more sensitive regarding his deformity. He could take no part in school athletics or outdoor sports. He could not dance. In town there were so many more people to notice his clumsy gait that he walked the streets with his head down, unable to speak to his neighbors, without friends, and afraid to show an interest in his feminine classmates lest they look with disfavor upon his deformity.

Fred finished high school. He pottered around town doing odd jobs. Because of his deformity most of the heavier, more lucrative labor was closed to him. One summer the boy was working in a nearby city where a crippled children's clinic was held. Neighbors reported Fred's condition and the boy received an invitation to attend the clinic. Surgical care was recommended for the deformed foot. Fred was fearful. He dreaded the operation, but more, he seemed to dread the trip to Boise and hospitalization among strangers. He deferred treatment and twice refused to come when he was called to the hospital. The public health nurse visited him after several months. She reassured him, interpreted the surgeon's recommendations, and pointed out that since he was already past twenty he would have to make his decision before long. Several weeks later Fred reported for his operation. While he was convalescing in the hospital, a field worker from the Vocational Rehabilitation Division visited him and helped him to plan and to finance a course in auto mechanics, the field in which he was most interested.

A year has passed. Fred has a good position

in the home-town garage. He tells the nurse he is able to dance and to play baseball. He has a girl. The neighbors report that Fred strides cheerfully along the streets, gaily greets his acquaintances, and is self-reliant and happy appearing. He is rapidly becoming one of the popular young men of the town. Fred's employer tells the public health nurse that he is an excellent workman and adds, "He meets the public better than anyone else in the shop."

Fred is one of the many children and young people for whom the Crippled Children's Service exists. Through a coördination of all the resources available, both state and local, the Service is trying to develop the potentialities of these children so that they may become useful citizens.

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THE COMMUNITY CHEST

THE COMMUNITY CHEST has become a nationwide enterprise in which the national organization of member chest agencies contributes to the success of the local chests and they in turn become part of a great social undertaking. This interrelationship is forcefully described in a book on *How to Raise Money*, by Lyman L. Pierce (Harper and Brothers, New York, 1932, page 214). The following passage from Mr. Pierce's book is of special interest at this time of spring campaigns:

"Every city is a unit in every national movement. Each city must come to recognize that it has its own equalized responsibility for the essential enterprises which are national in scope. Each city should not only participate, but it should capitalize its participation in national and state concerted social action. Great national enterprises have made possible

local successes in their fields. By concerted action they have achieved notable results which should be claimed as a part of the achievement of the units which have made these achievements possible. There is an appeal in national and worldwide enterprises which transcends any local appeal. Some of the most striking and fascinating results have been obtained through the national setup of member agencies in the community chest. What a pity it is to contribute to the provincialism of cities by dodging and neglecting the achievement of nationwide successes and worldwide influences which have been made possible by the united action of these community units! The chest is in a position to make this emphasis operative in every city in America. One of its major responsibilities is to be an enemy to provincialism."

Physical Examinations of Workers

By JOSEPH M. CONWAY

The Wisconsin plan for physical examinations of workers was developed by a committee drawn from labor and industry, and sponsored by the State Industrial Commission

PHYSICAL EXAMINATIONS of workers in industry have grown in importance in recent years, as an integral part of an industrial health program. Industries with special occupational hazards have felt the need for such a program as a means of prevention of occupational diseases. Broadened workmen's compensation legislation has resulted in physical examinations as a means of evaluating disability and reducing compensation costs. From the broad standpoint of a health service in industry, it is desirable to have a physical examination schedule for workers in all types of industries regardless of specific hazards. Such a schedule has been recently developed and proposed to Wisconsin manufacturers.*

JOINT THINKING ON THE PROBLEM

Some dissatisfaction on the part of labor toward the consequences of physical examinations prompted the Wisconsin Industrial Commission to seek a plan of examination procedure that would be acceptable to both labor and industry. Consequently, the Commission called a meeting of representatives of labor and industry in February 1938. As the result of this first formal meeting a declaration of principles concerning physical examinations was adopted. Some of these principles cover the following items:

*Industrial Commission of Wisconsin. Wisconsin Physical Examination Program. The Commission, Madison, 1939.

1. All physical examinations are to be made by physicians selected by the employer. The procedure to be followed in the event of a possible grievance on the part of the employee is outlined.

2. All examinations are to be paid for in full by the employer.

3. All time loss occasioned by examinations made while the employee is in service is to be assumed in full by the employer.

4. Transportation expenses occasioned by examinations are to be assumed by the employer.

5. Pre-employment examinations are to be made prior to employment, except that when a question of qualifications for a job exists the examination may be delayed 30 days.

6. All periodic examinations are to be made approximately at the time indicated by the examining physician.

In addition, a medical subcommittee was selected to consider the physical examination procedures. This committee was composed of two physicians selected by labor and two by industry, to meet in conjunction with the physician from the industrial hygiene unit of the State Board of Health.

The medical subcommittee acted upon five points in formulating a physical examination plan. After several meetings during the course of a year, the recommendations submitted to the main committee were briefly as follows:

1. In scope, the program is advocated for all types of industries. A general

physical examination covering minimum requirements is outlined in submitted forms. In addition, laboratory tests are to include a chest x-ray picture, a blood test for syphilis, a urinalysis for sugar and albumen, and a method for a quick indication of the red and white corpuscle content of the blood. Chest x-ray pictures are advocated as an important public health measure to exclude all cases of active tuberculosis. Blood tests for syphilis as a routine measure will be used to secure proper medical control for all syphilitics and to exclude communicable cases only.

Periodic reexaminations at two-year intervals are suggested. Special tests may be necessary at more frequent intervals, depending upon the type of industry or the physical condition of the worker. In any event, these further examinations must be controlled by the clinical judgment of the examining physician.

2. Forms are included for recording the physical examination and for submitting reports of the examination findings to the employee and employer.

3. The examining physician is to retain the original examination form. A separate report of the important findings is made in duplicate, one copy for the employer and the other for the employee.

The employee's family physician should receive detailed information from the examining physician upon request.

4. Statutory provisions are to regulate the admission of any examining physician's report as evidence in a compensation case.

5. The question of what conditions shall influence employment or continuation of employment, after an examination is made, is largely controlled by the judgment of the examining physician. Diseases, deformities, and disabilities are too variable in degree and extent to permit of a practicable schedule. It is the intent of a physical examination schedule to provide employment for all

workers within their physical capabilities. Some individuals will present disabilities which will act as a bar to employment and will require medical attention. Examples of some of the disqualifying disabilities are as follows:

Active tuberculosis.

Syphilis in the communicable stages until proof of proper treatment is submitted. Syphilis of the central nervous system is considered dangerous from the standpoint of accident hazard.

Communicable diseases of any kind, until recovery is complete.

High blood pressure only when associated with damaged heart or kidney function or both. Disabilities of these types are important in accident prevention.

Serious defects of vision or hearing in a hazardous employment where the safety of others depends upon the physical fitness of such afflicted individuals.

PROGRAM IS VOLUNTARY

The recommendations of the medical subcommittee were unanimously adopted by the main committee. The entire program was submitted to Wisconsin manufacturers upon a purely voluntary basis. It is admitted that perhaps imperfections exist in the present plan, but at least it serves as a foundation for future developments and improvements arising from actual application of the program. A pioneer plan of physical examination of such broad scope must proceed slowly to insure its success as an important industrial health measure.

The wholehearted coöperation of interested groups such as industry, labor, and the medical profession is essential before any advance in an examination program can be made.

Industry is to assume the financial obligation occasioned by physical examinations and therefore it is entitled to receive a service that will be beneficial to operating efficiency as well as humanitarian in principle. Certain industries with definite occupational health hazards have for some time past employed physical examinations as an adjunct to en-

gineering control for the prevention of disease. The present Wisconsin plan appeals to all manufacturers regardless of specific hazards on the basis that a sound health program is allied with a sound business program.

The confidence of labor groups must be obtained prior to seeking their cooperation in a physical examination program. Such a plan must not be oppressive in nature and must not result in discriminatory measures against employment. The Wisconsin schedule is intended to overcome such misgivings on the part of labor.

The responsibility placed upon the medical profession for evaluating an employee's physical status is of utmost importance to the success of this venture. Upon the clinical knowledge and judgment of the physician rests the decision in regard to the employee's fitness for work. The Wisconsin plan is a chal-

lenge to physicians to acquaint themselves with the working conditions of the plants in which they are called upon to render service. It should serve to stimulate research in regard to the ill effects of hazardous environments upon workers.

In conclusion the Wisconsin physical examination plan is presented as a pioneer step toward the advancement of an industrial health program. The present provisions will serve as a basis for promoting a practical and beneficial service for the majority of our adult population. The benefit to industry and labor is more than purely humanitarian; it is an economic and public health achievement growing out of the increasing complexity of modern industrial advancement. The medical and nursing professions can contribute much toward improving the health of the workers by their increased interest in and study of industrial health problems.

Winter Sun Baths for Baby

By MARION McKINNEY

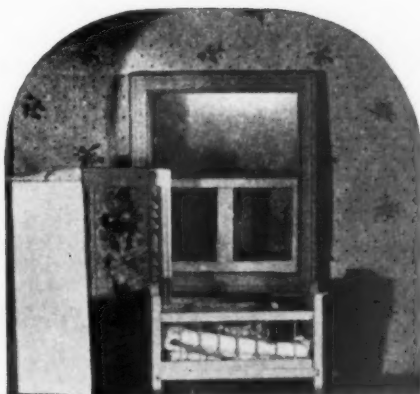
Inexpensive glass substitutes which will transmit ultraviolet rays can be used for winter sun baths for infants

THE ANTIRACHITIC power of the sunlight is dependent upon the presence of ultraviolet rays of certain wave lengths. Another factor affecting this power is the intensity of the rays. These factors vary at different seasons of the year, at different hours of the day, and in different parts of the country.

Although it is known that there are more ultraviolet rays in the summer sunshine than in the winter, it has been demonstrated by studies in several

northern cities that there is considerable antirachitic potency in winter sunshine even in the more northern parts of the country, particularly at midday. In localities where there is a great deal of smoke or dust in the air or where much of the weather is foggy or cloudy, this would not be true, since the ultraviolet rays cannot penetrate the screen formed by these particles in the air. In the less thickly settled regions and in the more favorable climates, however, there are many bright winter days when the ultraviolet radiation is quite extensive.

Dr. E. T. Wyman reported favorable results in Boston from placing undressed rachitic babies in their cribs all day long



Exhibits showing summer and winter sun-bathing

in the winter directly in front of windows made of material which would transmit the ultraviolet rays.¹ In New York, Dr. G. W. Caldwell and Dr. R. H. Dennett gave infants and children sun baths two or three hours daily throughout the winter, as a prophylactic measure, in front of special windows transmitting ultraviolet rays. They conclude that there are ample ultraviolet rays in the antirachitic range in this latitude during the winter to be of definite value to those receiving them when exposed in the direct path of the sun's rays through a substance which will transmit the ultraviolet rays.²

It is not difficult to interest mothers of young babies in giving them sun baths during the summer months. Putting the baby out of doors is easy and pleasant, and the value of the process seems apparent to the mothers.

RAYs DO NOT PASS THROUGH GLASS

When winter comes, it is a different story. Under ordinary conditions within doors, babies get no ultraviolet rays since these do not pass through window glass. Babies are sometimes wrapped and left in their carriages in a sunny spot out of doors, but under these circumstances, very few of the ultraviolet rays get to the baby's skin.

The pediatrician in charge of the child health service in the Westchester County Department of Health wanted to stimulate interest among the clinic mothers in winter sun baths for their babies. An attempt was made to teach these mothers to leave their unclothed babies in the winter sunshine before open windows with the temperature of the room maintained at 80° F. This was not very successful because they felt that they were overexposing their babies and burning fuel unnecessarily to keep the room warm enough on very cold days.

On investigation, it was found that there were several inexpensive glass substitutes which would transmit ultraviolet rays and which could be used in making windows to replace the regular windows for sun baths on extremely cold winter days. According to a recent communication from a commercial company, plain, colorless cellophane (300 gauge) is about 70 percent efficient in transmitting ultraviolet rays of the effective wave lengths. There is another glass substitute composed of a wire-mesh screen filled with a celluloidinous material which will transmit considerable quantities of the short rays excluded by window glass, according to a report of the Council on Physical Therapy of the American Medical Asso-

ciation, published in the *Journal of the American Medical Association* (May 14, 1927, page 1562). These materials lose some of their power of transmitting ultraviolet rays after being used for a period of time, but they are so cheap that they can be easily replaced when they begin to get dark or cloudy.

MINIATURE EXHIBIT SHOWN

Having found some suitable material for screens for winter sun-bathing, the next step was to interest the mothers in using these screens. An exhibit was worked out for the purpose. Two small dioramas were constructed, painted gray on the outside and a soft blue on the inside, and lighted with small display bulbs wired to the ceilings. In each, a simple scene was set, one to illustrate summer sun-bathing, and the other, winter sun-bathing. The former shows a baby doll lying on a blanket on a piece of grass with a flowering branch in the

background and the light streaming down on him. For the winter sun bath, the interior of a room is shown with a doll in a screened crib which stands in front of a window. The lower sash is pushed up and replaced by a screen of cellophane through which the sunlight is shining on the baby. By the lighting effects and pleasing color combinations, attention is attracted to the exhibit. Miniature models of screens made with cellophane and the other glass substitute described above are part of the display.

The exhibit has been shown in the child health conferences, with someone to answer questions about it, and mimeographed directions for constructing and using the screens have been given out. A set of general instructions on sun-bathing prepared by the director of the child health service is also available for distribution. The exhibit and instructions have proved of definite value in stimulating interest in winter sun-bathing.

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SCHOOL BOOKS AND COMMUNICABLE DISEASE

THE CITY board of health of the city of New York has revoked the regulations prohibiting the use of schoolbooks in homes where communicable diseases have been reported. The change has been made because the health authorities now say that transmission of communicable diseases is rarely effected by inanimate objects. This has been found true in the so-called childhood diseases, such as chickenpox, mumps, measles, scarlet fever, and diphtheria.

—From *The Journal of School Health*, November 1938

Treatment of Diabetes by Diet and Insulin

By HOWARD F. ROOT, M.D.

The public health nurse should understand the diabetic problem so that she may serve as teacher and nurse, not merely for the patient but for the entire family

THE STEADILY increasing number of diabetic patients in the United States presents an opportunity for the community nurse, which has not yet been fully recognized. The public health nurse sees at first hand and at close range the need for teaching patients and their families the diabetic diet and the use of insulin, as well as many other practices which will prevent the dreaded complications of acidosis and gangrene. There is need in many communities to adapt the diabetic diet to national dietary customs so that the food to which the entire family is accustomed can be utilized successfully for the diabetic patient. The nurse should understand the diabetic problem as a whole, so that in the future she may increasingly serve as teacher and nurse, not merely for the patient but for the entire family.

FINDING NEW CASES

All nurses have been taught to suspect diabetes when any patient loses weight and strength in spite of an increased appetite for food and the increased drinking of liquids. Furthermore, the symptoms of itching of the genitals or of the skin generally, recurring boils, blurred vision, neuritic pain, and indeed unexplained loss of weight and strength, should lead to examination of the urine. More important, however, is the knowledge that a few years ago, the duration of life of patients whose diabetes was discovered by insurance examination in early adult life before symptoms had

developed was twice that of patients whose diabetes was discovered after symptoms had begun. Even now the early diagnosis of diabetes will save many lives, otherwise sacrificed to coma or infection. Therefore, all relatives of a patient known to have diabetes should have their urine tested once a year. Better still is the rule that everyone should have his urine tested once a year, and that if any sugar is found, a blood sugar test or a glucose tolerance test should be performed.

IMPORTANCE OF THE DIET

In the treatment of diabetes the diet is of fundamental importance. In the first place, it is only by means of a diet suitably chosen and prescribed that the most efficient use can be made of the insulin which the patient manufactures for himself or which he receives by injection. In the second place, many cases of diabetes—particularly in middle and late life—if treated with the proper diet may not need extra insulin. In the third place, in the diabetic patient the use of a diet which is inadequate in the vitamins and minerals may lead to serious deficiencies. The treatment of a case of diabetes should last for years and indeed for life. Therefore, not only must the diet be planned for a long period but patient, nurse, and physician must be ready to make alterations in dietary treatment in accordance with changes in the patient's condition. The occurrence of infection not only may have a prompt

and serious effect upon the tolerance of the patient, increasing the blood sugar and increasing the amount of insulin needed, but also may affect the requirement of the patient for vitamins.

Every diabetic patient and his family should know the simple and fundamental requirements of the diabetic diet. The average diabetic diet consists of one slice of bread and butter and an orange* at each meal, with moderate portions of meat, fish, eggs or cheese, cereal for breakfast, liberal servings of 5 and 10 percent vegetables at noon and night, and a pint of milk and cream with changes in their proportions according to the body weight and the physical activity of the patient. Such a diet contains approximately: carbohydrate 150 grams, protein 85 grams, and fat 90 grams—1750 calories in all.

The dietary treatment of a case of diabetes is a serious matter and the problem should be stated frankly to the patient and his family. Success will depend upon faithful coöperation between nurse, doctor, and patient, and the best results will be obtained when the patient steadily increases his knowledge of his disease. Sudden changes in dietary treatment are often dangerous. Thus, particularly in older patients whose heart and kidneys may have suffered, the discovery of diabetes and then a sudden restriction of the carbohydrate in the diet and an increase in the fat may sometimes provoke not only acidosis but even a serious failure of the kidneys. Changes in such patients should therefore be made gradually. Sudden changes in diet, such as the omission of food—particularly carbohydrate food—in either young or old patients who are receiving insulin may result in an exaggeration of the effect of the insulin and an insulin reaction.

The object of treatment and the relations of the diet to the symptoms of the

disease should be made graphic. The patient should understand that if the urine contains 4 percent sugar and 4 quarts are voided, 160 grams (or more than 5 ounces) of sugar are lost each day in the urine. With the control of glycosuria and the reduction of the amount of sugar in the urine by means of diet, he will be able to appreciate the reduction in the troublesome polyuria, pruritus, nocturia, and thirst.

INSULIN

All human beings as well as animals need insulin. The diabetic patient must have insulin either secreted by his own pancreatic islands of Langerhans or received by injection. It is an error, therefore, to regard insulin as an artificial drug or to hesitate to use it for such a reason. The amount of insulin which the normal individual or the diabetic patient actually manufactures from hour to hour and from day to day is unfortunately unknown. Recently, however, Professor C. H. Best* of Toronto has shown that the amount of insulin to be found in the pancreas of experimental animals varies with the type of diet which is utilized. Under the conditions of his experiments, diets in which the carbohydrate, protein, and fat were suitably balanced produced a great increase in the amount of insulin present in the pancreas. Probably the amount of insulin produced in the body and certainly its efficiency in action are influenced by a wide variety of factors. Among these may be mentioned febrile infections, acidosis, and starvation or abnormally proportioned diet. All these factors must be considered, watched for, and avoided in the diabetic patient who is undergoing treatment with insulin.

At present two types of insulin are chiefly used: the one, quick-acting crystalline insulin or solution of zinc insulin

*Or other fresh fruit.

*Haist, R. E., Ridout, J. H., Best, C. H. "Diet and the Insulin Content of the Pancreas." *American Journal of Physiology*, July 1, 1939, p. 519.

crystals similar to but in various respects better than the original insulin, and the other, slow-acting protamine zinc insulin. The action of protamine zinc insulin is prolonged so that with moderate doses the effect may be expected to last for from 24 to 30 hours. Its action, however, is slow so that during the first six hours after the injection the effect may not be sufficient to counteract the tendency for the blood sugar to rise after the morning meal. On the other hand, crystalline insulin acts rapidly and for a period of six to eight hours. During this time the blood sugar falls rapidly. At present, crystalline insulin is used commonly in combination with protamine insulin, and is particularly used in cases where rapid action is desired, as in acidosis or in surgical emergencies.

Normally insulin is being delivered to the blood stream throughout the day and night at a rate which changes in accordance with needs from hour to hour. Therefore, to simulate the normal administration of insulin, one would need to give small doses of insulin almost every hour. It is true that one can often increase the efficiency of a certain dose of insulin if it is divided into small amounts and given at frequent intervals. On the other hand, practical necessity urges us to find the most efficient way of administering insulin so that if possible it can be given once a day rather than three or four times a day. If one uses protamine zinc insulin, in the majority of mild diabetic patients a single dose is sufficient. However, usually it is necessary, particularly in younger patients, to use one dose of crystalline insulin and one dose of protamine zinc insulin, both injected before breakfast. On the average, 30 units of insulin a day is the dose. A typical division of this dose would be 8 units of crystalline insulin and 22 units of protamine zinc insulin.

It is difficult to calculate the insulin

requirements from the amount of carbohydrate in the diet or the weight of the patient because we never know how much insulin the patient himself may be manufacturing. However, in general it has been estimated that usually one unit of insulin will cause the metabolism of about 2 grams of carbohydrate. It is important to remember, however, that this value is by no means constant and will change under the influence of infection or acidosis or improvement in the patient's diabetes. Thus, our patient taking 30 units of insulin could take 60 grams of carbohydrate—and this very likely in addition to the 90 grams for which the insulin of his own pancreas provides.

Insulin should not be injected repeatedly in one place. Some children find that repeated injection in one spot is less painful. Loss of efficiency of the insulin results so that the amount of insulin required will be greatly increased. Therefore, it is important to be sure that the skin of the thighs, arms, and back is mapped and that each injection is given in a different spot so that the same spot is not used more than once a month.

INSULIN PRESCRIPTION

Although the ordering of insulin dosage is the physician's responsibility, the nurse should be familiar with the general principles underlying the prescription of insulin so that she may be intelligent in administering it or teaching the patient to do so.

Orders for insulin must be reviewed twice a day, particularly in hospital cases or during acute illness, so that the dose may be changed as the patient changes. Particularly during acute illnesses or at the time of surgical operation, it is convenient to write insulin orders contingent upon urine tests. Thus, the diet having been prescribed, the insulin order may be written as follows: Test the urine every four hours.

If the color is red give 20 units; if yellow, give 15 units; if yellow-green, give 10 units; and if green, give 5 units. As a result of such an order, no insulin would be given when the urine is sugar-free. Insulin is prescribed in units, whether U20, U40, or U80 is employed. If the syringe contains 1 cc. divided into tenths, and insulin of U-40 strength—*i.e.*, 40 units to 1 cc.—is used, each line means 4 units of insulin. In general, when patients are using large doses of insulin, U40 or U80 is employed.

Resistance to insulin occurs occasionally in patients who have some complications such as an infection, thyroid disease, or liver disease; then a patient who previously required 30-40 units a day may in the course of a few weeks require five or ten times as much.

Physical exercise always increases the effectiveness of the insulin. Therefore, all patients should be warned that if unusual exercise is taken, either the insulin dose must be somewhat reduced or else extra food must be taken about two to three hours after the dose.

INSULIN REACTIONS

Rarely is an insulin reaction serious. This is certainly true if attention is paid to the early symptoms and treatment promptly given. When a patient develops symptoms such as hunger, nervous instability, sweating, numbness or tingling of the tongue or lips, double vision, faintness, tremor, unsteady gait, unconsciousness, or convulsions after an injection of insulin, he is having an insulin reaction due to low blood sugar. Usually such a reaction occurs three or four hours after the dose of crystalline insulin but it may occur somewhat later. With protamine zinc insulin, reactions are more likely to occur before breakfast. Lack of the usual food supply—particularly carbohydrate—either in the diet or as a reserve supply in the body favors the reaction; and the same thing would occur if the food which had been eaten

was unutilized because of failure to be absorbed in the stomach or by reason of vomiting or loss in diarrhea.

Treatment consists of immediately taking carbohydrate in the form of candy, a lump of sugar, or orange juice, or of giving glucose solution intravenously. All diabetic patients should know that insulin reactions may occur, in order that they may take such treatment upon the first development of the symptoms. All patients undergoing unusual physical exercise or especially patients driving automobiles should have carbohydrate in the form of a lump of sugar or piece of chocolate in the car with them. Before going swimming late in the morning, diabetic children as well as adults should have a lunch consisting of 10 grams of carbohydrate in the form of orange juice or a cracker and milk.

METHODS OF TREATMENT

The general rationale of treatment has been described above. The actual steps in treatment of a newly discovered case of diabetes are of interest to the nurse who wants to be well informed on this subject.

The earlier the diagnosis of diabetes is made and the sooner aggressive treatment is begun after the discovery of diabetes, the better the results and the longer the life of the patient will be. The inauguration of treatment, either in a newly discovered patient or in a patient with diabetes of long duration who has not had treatment, is best begun in the hospital. If this is not feasible, treatment should begin immediately by the prescription of a temporary diet containing from 20-25 calories per kilogram of body weight, with carbohydrate 100-130 grams, protein 50-60 grams, and fat 60-80 grams. The use of protamine zinc insulin should be started at once with a dose which might be 10 units before breakfast on the first day, if no acidosis was present and the amount of

TABLE I
TREATMENT OF MR. X., A DIABETIC, AGE 28 YEARS (CASE NO. 14397)

Date 1939	Urine sugar		Daily diet			Blood sugar		Insulin	
	Reduction percent	Total grams	Carbohydrate grams	Protein grams	Fat grams	Calories	Percent	Time	Time given
Nov. 2	5.8	44	52	30	35	643*	0.35	2:00 p.m.	10 10 6:30 p.m. 9:30 p.m.
3	3.4	27	140	79	92	1604	0.19	7:00 a.m.	10 + 24 8 6 7:00 a.m. 12:00 noon 5:00 p.m.
4	0.9	13	141	80	94	1730	0.14	11:00 a.m.	12 + 28 8 7:00 a.m. 12:00 noon
5	0.9	11	141	80	94	1730	0.16 0.08	7:00 a.m. 11:00 a.m.	12 + 28 7:00 a.m.
6 7	0.2 0.3	2 4	159 159	83 83	94 94	1814 1814	0.10 0.10	7:00 a.m. 4:30 p.m.	8 + 28 8 + 28 7:00 a.m. 7:00 a.m.

NOTE: Under "insulin," the figures in italics indicate protamine zinc insulin. Other figures indicate crystalline insulin.

*This is the evening meal only, since patient was admitted in afternoon.

TABLE II

DISCHARGE DIET

Carbohydrate 180 grams—protein 95 grams—fat 119 grams

Breakfast			Noon			Night		
Foods	Grams	Portions	Foods	Grams	Portions	Foods	Grams	Portions
Egg	60	1	Meat, cooked	90	moderate serving	Meat, cooked	90	moderate serving
Bacon	30	6 strips	5 percent vegetables	150	$\frac{1}{2}$ cup <i>or</i>	5 percent vegetables	150	$\frac{1}{2}$ cup <i>or</i>
Oatmeal, dry	15	$\frac{1}{2}$ saucer <i>or</i>	10 percent vegetables	75	$\frac{1}{4}$ cup	10 percent vegetables	75	$\frac{1}{4}$ cup
Oatmeal, cooked	120	$\frac{1}{2}$ cup	Butter	10	1 square	Butter	15	$1\frac{1}{2}$ square
Butter	10	1 square	Cream, 20 percent	30	1 ounce	Cream, 20 percent	30	1 ounce
Cream, 20 percent	60	$\frac{1}{4}$ cup	Orange	150	1 serving	Orange	150	1 serving
Milk	120	$\frac{1}{2}$ cup	Potato	75	medium	Potato	75	medium
Orange	100	1 small <i>or</i>	Bread	30	1 slice	Bread	30	1 slice
Grapefruit	150	1						
Bread	30	1 slice						
Lunches								
1 soda cracker at 10 a.m.			1 soda cracker at 3 p.m.			2 soda crackers with $\frac{1}{2}$ square (5 grams) butter at bedtime		

Approximate equivalent: 1 small orange (100 grams) = $\frac{1}{2}$ banana (50 grams) = $\frac{1}{2}$ saucer oatmeal (15 grams dry or 120 grams cooked) = 2 large saucers (300 grams) 5 percent vegetables = 1 large saucer (150 grams) 10 percent vegetables = potato size of egg = $\frac{1}{2}$ slice (15 grams) bread.

sugar was not excessive; or it might be as much as 30 units if acetone was present in the urine and the urinary sugar was excessive.

The patient should be instructed how to test his urine by means of the Benedict test. He should be instructed to collect the urine four times a day, including all the urine passed in the morning as specimen No. 1; the urine passed in the afternoon as specimen No. 2; the urine passed between supper and bedtime as specimen No. 3; and the urine passed during the night and upon rising in the morning as specimen No. 4. Thus far the treatment can be carried out either in the physician's office or in the hospital.

The next day the insulin might be increased to 20 units, and each day the insulin dose might be increased by 10 units until 30 units were taken. If when 30 units of protamine insulin have been taken, the glycosuria continues moderate in amount, it is often advantageous to add a second injection of crystalline insulin before breakfast. A small dose of 4 to 8 units of crystalline insulin, to be given in one leg, together with 30 units of protamine insulin injected in the other leg, may control the great tendency for the blood sugar to rise after the breakfast meal and so enable the more slow-acting protamine insulin to control the blood sugar and glycosuria during the latter part of the day.

As an example, Mr. X., 28 years of age has had diabetes for four months. The first urine specimen contained 6.5 percent sugar at the office, and treatment was begun immediately upon his admission to the hospital. Table I summarizes the diet, insulin, and changes in the urine sugar during his hospital stay. At discharge, he was given the diet indicated in Table II.

ALTERATIONS IN DIET

It is not necessary to change the diet in most patients more often than once in

two or three days. During intercurrent infections or such complications as diarrhea, alterations of the diet on sudden notice may be necessary. Actually, in some patients the urine may become sugar-free so rapidly and the sugar in the blood fall so rapidly that it is important to watch the urine tests two or three times a day and sometimes to make rapid increases in the carbohydrate of the diet in order to keep pace with the rapid improvement in carbohydrate tolerance.

In case of diarrhea, rather simple adjustments of the diet are often sufficient, particularly combined with simple remedies such as bismuth subcarbonate; thus, grapefruit, orange, and raw fruit are eliminated as well as coarse vegetables and salads. In their place, boiled milk and soda crackers may be substituted. In place of the fruit at each meal, equivalent perhaps to 40 grams of carbohydrate and vegetables equivalent to perhaps 20 grams of carbohydrate, the pint and a half of milk will provide 36 grams of carbohydrate, and 4 crackers, 20 additional grams.

The diabetic diet need not be extremely expensive. Less costly meats may be used in place of steaks and chops. Olive oil may be taken in place of cream, especially for patients whose national dietary habits have included it. The protein and fat of the diet, because convertible in part into sugar, must be prescribed carefully. But the amounts may often be controlled by insisting that the patient keep his weight within 10 percent of average and by using protein in the proportion of one gram for each kilogram of body weight.

This is the second of a series of articles on diabetes by the physicians of the George F. Baker Clinic, Boston, Massachusetts. The next article will appear in an early issue.

The George F. Baker Clinic has a collection of stereopticon slides on the subject of diabetes and its treatment which may be borrowed without charge by doctors, nurses, or medical societies for meetings or classes.

Conserving the School Child's Hearing

By LESTER K. ADE, Ph.D.

Pennsylvania initiates a program for the conservation of hearing of its school children through audiometric testing and follow-up of children with hearing defects

RECENT STUDIES indicate that a large proportion of school children are handicapped in their school work and retarded in their progress because of subnormal hearing. The close relationship between hearing and health imposes on school administrators the responsibility of recognizing this problem. The conservation of hearing by early detection of hearing loss and proper follow-up work is now the direct, legally imposed responsibility of every school administrator in the Commonwealth of Pennsylvania.

In view of the vital importance of the conservation of hearing in the school health program, the General Assembly of Pennsylvania has authorized the Department of Public Instruction to purchase the necessary equipment to test the hearing of all school children in the Commonwealth. The Act further specifies that the department shall prescribe to boards of school directors and medical inspectors of schools, suitable rules and instructions relating to the hearing tests and examinations to be made.

To get the program under way in Pennsylvania, the superintendent of public instruction appointed a state advisory committee to cooperate with the department in setting up objectives and formulating procedures to carry on the work. The objectives agreed upon at the inception of the program are:

1. To detect incipient cases of hearing loss in children in order that subsequent serious impairment of hearing may be prevented.
2. To discover and recommend for treat-

ment cases of subnormal hearing acuity due to pathological conditions.

3. To recommend that necessary educational adjustments be made in all such cases to fit the needs of the individual child. Such adjustments may include advantageous seating, lip-reading, voice and speech training, special class education, and vocational counseling.

CLASSIFICATION OF PUPILS

While the program implies the inclusion of all pupils in the schools of the state—approximately two millions—it was clearly impossible to examine all the first year. Accordingly, it was agreed that attention should be given to those who most needed the service.

Among these were pupils of any grade who had a recorded hearing loss of nine decibels or more in the final test of the previous year; all pupils who have had communicable diseases within the year; all who have been habitual absentees because of colds; those who have running ears or other inner ear trouble; those who were not promoted last year; or those whose attitude of apparent indifference toward school work may be attributed to defective hearing.

In addition to these special cases, all pupils of grades three and seven were examined in order to begin a sequence of examinations by class.

A careful planning of procedures was imperative in the effort to accomplish

NOTE: This description of the first year of Pennsylvania's audiometric program was prepared by Dr. Ade, former superintendent of public instruction and now president of State Teachers College at Mansfield, as of May 1939.

the great number of examinations contemplated in the program. To effect a close coordination of agencies and activities in the work, a brief manual on the organization and administration of the audiometric testing program was prepared and distributed to all concerned.

This manual outlined the test schedule with reference to the 2500 or more school districts in the state. It likewise gave a detailed time schedule so that each district would have use of the audiometric instruments during a sufficient period to examine the pupils to be included in the project. The largest portion of the manual was devoted to the procedure to be followed in conducting the tests.

As the first step in instituting the program, the Department of Public Instruction sent out a coordinator, a member of the regular staff, to give a demonstration test in strategic centers throughout the state. School officials, nurses, and others from surrounding communities interested in the program would come to observe, so that when the testing program reached their respective districts they would be generally acquainted with the procedure. The program was directed by the chief of the Division of Health and Physical Education of the Department.

The work was carried on through the offices of district and county superintendents. In introducing the testing program in a given school district, the purpose, procedures, and plans were explained to the group of school personnel and lay people concerned with the activity. This group usually comprised county and district superintendents, supervising principals, medical inspectors, school nurses, health and physical education instructors, and members of school boards. The number of those attending these demonstrations varied from ten to one hundred, with an average attendance of about thirty-five.

The introduction of the plan consisted

of three phases. First, there was the open meeting with interested people during which various questions were discussed, such as the operation of the audiometric machines, the room conditions required for the testing, the school materials to be used, directions for giving the tests, the arrangement of pupils in the room, and the scoring and report of the testing.

The second phase was the administration of the test to the adult group. This process was of great value in assisting those who were to administer the test to children to interpret the reactions of pupils. It also gave them first-hand knowledge in regard to scoring papers, arranging sets in advantageous positions, and undergoing other experiences which they would meet in carrying out the plan in the schools.

The third phase consisted of a demonstration audiometric test with a class of 35 or 40 children who were brought in for the purpose. Following this demonstration, those who were to have charge of the work asked questions of the demonstrator and thus cleared up every problem that could be anticipated. Throughout the first day of testing, the demonstrator remained in the community to supervise and assist with the program.

The primary responsibility for giving the tests rests with the superintendents, who in turn rely on the teachers for the actual administration of the routine.

Almost a hundred audiometers were provided, which made it possible to test between two and three hundred thousand children the first year, and a still larger number the second year. Each district using the machines was responsible for the transportation to the next district on the schedule. In this process, machines were not infrequently damaged. If they could not be repaired locally, they were returned to the Department, where a mechanic was made available for the service.

In planning for the program of audiometric testing, the department maintains a loan service whereby county and district superintendents or other school officials may apply for the use of equipment necessary in this special program. Ultimately, it is hoped that school districts will purchase their own accessories, record blanks, and in some cases even the instruments themselves.

STATE TEACHERS COLLEGES

The Act providing for the audiometric testing provides for instruction in the use of audiometers to prospective teachers enrolled in the fourteen teachers' colleges of the state. The same equipment used in the public schools is made available in these professional schools, so that the testing program may be continued on an efficient basis in future years.

The use of the audiometers in the teachers' colleges affords an opportunity for instruction and practice in the best method of testing hearing of children. The instruments are available also for audiometric service in the laboratory schools of the college, as well as in the school districts within the college service area. The entrance health examinations of candidates are likewise supplemented by audiometric testing.

The fourteen state teachers' colleges of Pennsylvania are distributed in such a way as to cover every area of the state. The program of these several institu-

tions, therefore, permeates practically every school district.

During 1938-1939, some seventy demonstrations of the techniques of audiometric testing were given in the state. Practically all of the sixty-six counties as well as many independent districts were reached.

A follow-up program, remedial and educational, is planned for all children whose hearing is definitely subnormal.

The plan has been the same as that followed in any other part of the physical examination of pupils. Reports are prepared on the findings of the test and submitted to the proper school authorities for such action as they may see fit to take. Parents are informed of any unusual conditions in their children. Doctors, nurses, school and home visitors, representatives of civic groups, and others interested in the school child's health have participated in the plan from its inception. The public health nurses have played an important part in the follow-up program. The coöperation of physicians, nurses, and parents in carrying out this work has been gratifying.

With the teachers' colleges preparing candidates for administering audiometric testing, and with school districts either purchasing or renting equipment through the Department of Public Instruction, there is every reason to believe that audiometric testing will become a universal practice in the schools of Pennsylvania within the near future.

How Effective Are Home Visits?

By HENRIETTA LANDAU, R.N.

A SERIES of five dramatic skits entitled "Home Visits—How Productive?" was presented by the Division of Public Health Nursing of the New York State Department of Health at the Department's annual conference last year. Each skit portrayed a cross section of two visits—the first a poor, or negative visit. The second a positive and—it is hoped—a more effective one. To make the contrast the more striking, the same family situation was used for both visits. Five public health nursing services were considered, including a visit to an expectant mother, to a woman suspected of having cancer, to a young woman with early syphilis, to a family in which the children were undernourished, and to a family with a two-months-old infant. The skits were prepared by the educational supervisor of the Division of Public Health Nursing, in collaboration with the various special consultants in the Department. Nurses from various parts of the state, from both voluntary and official agencies, were chosen to participate.

The chairman of the meeting explained briefly the reasons for presenting the program, which may be summarized as follows: Although everyone agrees that *teaching* is one of the main functions of the public health nurse, surveys and our own experience indicate that home visits are not as productive as we would expect them to be. Our families are apparently not *learning*. Are the public health nurse's teaching limitations due to the fact that she does not know *what* to teach, or does not know *how* to teach—or both? These points were left with the audience for later discussion.

Before the curtain rose for each skit,

the chairman, acting as narrator, gave a brief history of the case to be presented. The skits were enacted on a darkened stage, with a strong spotlight playing on nurse and patient. When the participants completed the poor visit, they moved to an adjoining table—the spotlight moving slowly with them—to present the more positive scene. The curtain dropped at the end of each skit and a five-minute planned discussion followed. Both the actors and discussants were local talent, so that the program was presented by nurses representing many sections of the state. It was truly a statewide project. At the conclusion of the program, the discussion was thrown open to all.

The audience had been asked to analyze the visits as they were being enacted, both for content and method of teaching. In order that their analysis might be given some definite form and direction, the following suggestions and questions were listed on the program:

The point for argument may well be, then, not whether we are teachers but how constructive, how effective, is our teaching? There are basic principles which apply to all teaching. Some of these we list below in the form of questions which could be applied to any visit:*

1. Did the nurse encourage the family to express its own needs and interests?
2. Did she try to meet these needs and interests even though she had other plans for the visit?
3. Was the information she gave specific rather than general and vague?
4. Was her language simple and easily understood by patient?
5. Was the information given limited to the

*These questions were inspired in part by Dr. Mayhew Derryberry's article, "The Nurse as a Family Teacher." PUBLIC HEALTH NURSING, June 1938.

amount patient could remember and absorb at one time?

6. Did the nurse carefully give reasons why things should be done, rather than just tell patient to do them?

7. Wherever possible, did she show patient *how* to do, as well as tell her *what* to do?

8. Did she review with patient the information she had taught on previous visits?

9. Was she quick to commend the family for efforts or progress made, no matter how small?

10. At the end of the visit, did she summarize the important facts?

The program, judging from the reaction of the group, was a successful one. Interest was held throughout, in part no doubt because of its excellent presentation. (Nurses are versatile!) Those behind the scenes were impressed with the thoughtful attention given by the audience to every move made by the participants. There is no sure way, of course, to determine how much carry-over there will be toward changed or improved practice! The opinion was fairly general that the technique used—presenting a negative and a positive side and raising some definite questions in advance—supplied the audience with

criteria by which to judge the visits presented.

The discussion centered mainly on points in methods of teaching. The question arose as to whether it would be wise to present uncompleted cross sections of visits and a negative as well as a positive visit, to a lay public. It was decided that such a program could profitably be used as a staff education project for nursing groups, and perhaps for lay nursing or public health committees, but not at a general public meeting. The difference between the two visits could be brought out to interpret to committee members the fact that the nurse who held the patient's interest and attention did so because she knew *what* and *how* to teach; and that in most instances it takes certain basic training and experience to acquire the knowledge and ability to make an effective home visit.

Following is one of the skits, negative and positive, presented at the Public Health Nurses' Section of the Annual Conference of Health Officers and Public Health Nurses in Saratoga Springs, New York, June 28, 1939.

WHAT IS WRONG WITH THIS VISIT?*

SITUATION: Visit to infant seven weeks old. The family was not known to the nurse until the fourth week postpartum. Weekly visits are being made until the nurse is certain the mother has acquired the fundamental principles of child care. This is the third visit.

PURPOSE OF VISIT: General health supervision.

(The nurse has weighed the baby and returned him to his crib in the next room.)

MOTHER: You know, I was sure that baby wasn't gaining any. He's been fussing such a lot.

NURSE: I wonder what is wrong. He's only gained two ounces.

MOTHER: How much is he supposed to gain?

NURSE: Oh, most babies gain five to eight ounces a week, if they are all right. Is he getting enough milk, do you think?

*This is not a complete visit but a cross section or flash of one.

MOTHER: He seems satisfied right after nursing, but then he fusses later. My husband thinks I ought to nurse him more often.

NURSE: Maybe he isn't getting enough. (*Baby cries.*)

MOTHER: Oh there he goes again. I'll give him his water. (*Mother, preparing bottle, contaminates nipple.*) Oh dear, I'm always all thumbs when I do this.

NURSE: (*Looking on and smiling.*) It is a little hard at first, isn't it? Oh, you shouldn't put your fingers on the part that goes in the baby's mouth.

MOTHER: (*Appears embarrassed and looks at hands.*) That's right, my hands aren't very clean. (*Wipes nipple, after it is on bottle, with clean cotton from tray.*) (*Baby cries*) Oh, that baby (*Goes into next room. Nurse follows. Both return.*)

NURSE: How are you feeling, Mrs. Smith?

MOTHER: Oh, I'm tired and I've been a little upset lately about Tommy. A note came from school saying that we should take him to Dr. Smith about having his tonsils out. Honestly it's just one thing after another! I'm awfully nervous about having that done. And the expense, too!

NURSE: I guess it won't cost so much. Have you taken Tommy to the doctor yet? You know, diseased tonsils are very serious things. They can cause rheumatism, heart trouble, and other conditions.

MOTHER: I suppose we'll have to have it done if the doctor says so.

NURSE: Have you been to see him about yourself yet?

MOTHER: No, he never examines me after the babies are born.

NURSE: Oh, but you should go to him. Let me see. How old is the baby now—about two months? You know, this book says, (*reading from parents' book, and pointing to line*) "It is essential"

THIS NURSE GETS RESULTS*

SITUATION: Visit to infant seven weeks old. The family was not known to the nurse until the fourth week postpartum. Weekly visits are being made until the nurse is certain the mother has acquired the fundamental principles of child care. This is the third visit.

PURPOSE OF VISIT: General health supervision.

(*The nurse had weighed the baby and returned him to his crib in the next room.*)

MOTHER: You know, I was sure that baby wasn't gaining any. He's been fussing such a lot.

NURSE: Well, let's see the baby's record. Your baby weighed 9½ pounds last week. That is *some* gain—two ounces since then.

MOTHER: How much is he supposed to gain a week?

NURSE: Oh, babies should gain about five to eight ounces a week. But you know,

*This is not a complete visit but a cross section or flash of one.

no two babies are alike. As long as he makes a steady gain—that usually shows he is thriving in other ways—I wouldn't worry too much. Perhaps together we can find the reason why he has not made the usual gain this week. You say he has been fussing a lot?

MOTHER: Well, he seems satisfied for a little while—then he wakes up and cries again.

NURSE: Did you happen to notice how long he seems satisfied? Just for a short time—10 or 15 minutes? Or longer—say an hour or two?

MOTHER: Seems as though he sleeps 10 or 15 minutes. Then he starts fussing again and I give him some water. My husband thinks I ought to nurse him more often. I've been trying awfully hard to feed him at the regular times, but I'm quite discouraged.

NURSE: Don't get discouraged. We'll get at the bottom of this. How long does he nurse? Does he fall asleep during nursing?

MOTHER: Sometimes he does, but I wake him and try to keep him at it for about fifteen minutes.

NURSE: That should be long enough usually. Does he *empty your breast*?

MOTHER: No, lately he doesn't take it all, and still he doesn't seem satisfied. I am beginning to wonder if my milk is poor. I have lots of it but it's watery looking.

NURSE: Usually mother's milk has the right qualities. But if you have more milk than the baby takes, perhaps he doesn't get down to the richer supply. You know the first part has almost no cream in it. But as the baby nurses, the milk gets richer and is more satisfying. Your baby may be getting only that thin first flow of milk. Your doctor has asked me to watch out for that with all his babies. I'll show you how to express the first bit of milk so the baby will get to the richer supply and completely empty your breast.

MOTHER: I read something about that in the baby book that you left here.

NURSE: Yes, complete emptying of the breast helps to keep up your milk supply. Have you remembered to hold the baby over your shoulder after feeding, to help him expel the air he has swallowed?

MOTHER: Honestly, Miss Jones, I've been so worried about Tommy this last week, I just haven't paid much attention to that. (*Baby cries*) Oh, there goes the baby again. I'll give him his water. (*Mother, preparing bottle, contaminates nipple*) Oh dear, I'm always all thumbs when I do this.

NURSE: Let me show you a safe and easy way to put that on. You remember when we bathed the baby, we said it wasn't necessary to wash the baby's mouth. The best way to keep the baby's mouth clean is to be sure that everything that goes into his mouth is clean. So I'll wash my hands first.

MOTHER: (*Looking at her hands*) Tch! Tch! I forgot to do that!

NURSE: (*Nurse returns and applies nipple, using the proper technique, and explaining the procedure. She removes top from nipple jar with left hand, and shakes one nipple out on inside of cover*) The inside of this cover is clean. Grasp the nipple at its base, like this (*uses thumb and forefinger*). We'll be careful not to touch the part that goes into the baby's mouth (*Replaces cover and applies nipple to bottle*). See, we touched only the lower part.

MOTHER: Well, I'll practice that. (*Baby cries*) Oh, that baby! (*Goes into next room. Nurse follows. After brief interval both return.*)

NURSE: Did you notice? Even after that little bit of water the baby had air bubbles. You remember I told you that a baby usually swallows air right along with his nursing. Sometimes the air in his stomach makes the baby feel full and satisfied so he goes off to sleep. Then when he gets rid of the air, he is hungry because he has not had a full feeding and he wakes up and fusses. After the baby has nursed a few minutes, if you put him over your shoulder in an upright position the air can escape and he will be ready to nurse more. We call it "bubbling" the baby.

MOTHER: I guess I won't forget to do that again. If only Tommy was off my mind.

NURSE: You said you're worried about Tommy. What seems to be the trouble?

MOTHER: Oh dear, I'm so tired and so upset about him. A note came from school saying that we should take him to Dr. Smith about having his tonsils out. Honestly, it's just one thing after another! I'm awfully nervous about having it done. And the expense, too!

NURSE: I'm sorry to hear about Tommy. Have you taken him to the doctor yet?

MOTHER: No, Tommy's so thin and hasn't much of an appetite. And he gets colds so easily. I hate the idea of an operation.

NURSE: You know, doctors often find that children with diseased tonsils act just as you say Tommy does. But after the tonsils come out they usually pick up beautifully. As for expense, in the long run having the tonsils out will probably save you a lot of doctor's bills. And Tommy won't lose so much school time, either. I'm sure you will feel better after you talk this over with your doctor. By the way—speaking of your doctor—you'll be sure to see him about yourself too, won't you? I'll send him a report of my visit with you so he'll know about Tommy and the baby too.

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A Deodorant for Care of Cancer Patients

By DOUGLAS A. SUNDERLAND, M.D.

The use of zinc peroxide as a deodorant which may be used in the care of cancer patients in the home is described here

ANAEROBIC infection is one of the major problems in the management of tumors of the oral, nasal, and paranasal cavities. This complication may occur in the primary tumor itself, in a postoperative cavity or surgical defect, or in an area of necrosis resulting from x-ray or radium therapy.

The causative organisms are for the most part saprophytes which are normally present in the mouth. When devitalization of tissue or new growth occurs, these bacteria assume aggressive qualities and give rise to a condition which is extremely unpleasant for the patient and his associates. The fetid odor and thick adherent slough, which are a characteristic part of this infection, are well known to all who deal with cancer of the head and neck. Because of this offensive odor, patients so affected present an even greater problem in the home than in the hospital. The infection may be acute, but is generally chronic. It is extremely resistant to ordinary measures. Simple oxygenic substances such as sodium perborate and potassium chlorate are ineffectual. Sprays of Dakin's solution and hydrogen peroxide have only a transient effect. Instrumental removal of slough is inadequate, and hazardous as a form of home treatment.

The work of Meleney* and others on the use of zinc peroxide in surgical

infections of an anaerobic nature led us to try its efficacy on cancer patients with secondary anaerobic infections. We have used it on the Head and Neck Service of the Memorial Hospital in New York City for the past year with uniformly good results.

Zinc peroxide is a white powder containing 45 to 50 percent ZnO_2 , 35 to 40 percent $ZnOH$, and 10 to 15 per cent $ZnCO_3$. It has the property, upon being mixed with water, of forming a suspension which liberates oxygen slowly over a long period of time. Heating the powder in a dry oven at a constant temperature of $140^\circ C$. for four hours in some way activates it so that the liberation of oxygen is increased. The heating process also sterilizes the preparation. The amount of oxygen given off by a suspension of powder which has not been previously heated is inadequate for clinical use. The preparation may be heated in small quantities in test tubes or in one-pound quantities in large petri dishes. The zinc peroxide thus treated remains active for at least three weeks after heating and should not be reheated. Only preparations of zinc peroxide designated as "medicinal grade" are satisfactory.

At the time of treatment the activated powder is mixed with water to form a suspension about the thickness of heavy cream. (This should never be done beforehand because when exposed to the open air the suspension rapidly dries and hardens.) The material is then introduced into the depths of the lesion by means of a 10-20 c.c. glass syringe with a semirigid nozzle. Gauze, also soaked in the zinc peroxide suspension, is then placed over the lesion. The area

*Meleney, Frank L. "The Prophylactic and Active Use of Zinc Peroxide in Foul-Smelling Mouth and Neck Infections." *Annals of Surgery*, January 1938, p. 32.

is sealed off with layers of vaseline gauze or boric ointment strips. If the area treated is on the skin surface, sealing off from the air is a simple matter. With intra-oral lesions it is more difficult, but with care can be accomplished. Adequate sealing off is important because of the above described tendency of the preparation to harden.

Recently, instead of mixing the powder with water we have tried mixing it with a 2 percent solution of a high viscosity polyvinyl alcohol, which was supplied to us for experimental purposes. We have found that with this preparation there is less tendency for the zinc peroxide to cake.

The zinc peroxide dressings are left *in situ* for 24 hours if the type and location of the lesion make this procedure practicable. Certain intra-oral tumors require more frequent care. If the packing interferes with eating, it is removed before meals, and replaced afterward, or applied after the evening meal and allowed to remain overnight. Each time the packing is changed, the residual zinc peroxide is removed by means of hydrogen peroxide or saline sprays.

The results of this treatment have been gratifying in most cases. In some instances the improvement has been dramatic, while in others it has been slower. A feature of all the patients treated has been marked diminution of the offensive odor within 24 hours. As a rule the odor has disappeared completely by the second or third treatment. Within two or three days clean granu-

lations appeared at the base of the areas treated and there was subsidence of surrounding swelling and inflammation of soft tissue. The duration of treatment has varied with the extent of the infection. Sometimes three or four treatments have sufficed. In other cases one or two weeks of regular applications have been necessary, followed by weekly or bi-weekly packings for several weeks. A few patients have required intermittent treatment over a period of months.

Several patients who have been unable to come to the hospital have been treated in the home with satisfactory results. In some of these cases the infection has been widespread and difficult to overcome, but in all of them, the deodorizing action has been marked. One of our patients was ejected from his rooming house because of the offensive odor which surrounded him. After several days of treatment in the hospital he returned to his establishment odorless, returning daily to the hospital for treatments.

Besides treatment in the Head and Neck Service of Memorial Hospital we have used zinc peroxide in dealing with infected tumors of other parts of the body: skin, breast, bone, and *cervix uteri*, with satisfactory results.

The simplicity of the technique of zinc peroxide treatment makes it well fitted for use in the home. We know of no contraindications to its use and have noted no undesirable sequelæ.

The use of urea as a deodorant for cancer patients in the home will be discussed in the March issue.

A GUIDE TO THE SCHOOL NURSE

A statewide program to detect and correct hearing defects in children is described on page 102.

Rural school nurses who find children with uncared for orthopedic defects will be interested in Idaho's program. Page 83.

Eye health is of vital concern to the school nurse. Part I of a study program on the subject appears on page 112.

The suggestions for winter sun baths for babies on page 92 are applicable to older children as well.

A Program for Staff Education

Eye Health

By ELEANOR W. MUMFORD, R.N.*

PROTECTING the health and safety of the eyes is a function of every nurse. To fulfill this function adequately the nurse must understand the structure and functioning of the eyes, the relationship of the eye to other bodily systems, and common hazards to the eyes from illness or injury.

In this study outline, important aspects of eye health are correlated with other health problems and programs, in order to stress the desirability of integration with related subjects. In schools of nursing the outline may serve as reference material to assist instructors in a more adequate correlation of this subject with units on obstetric nursing, the nursing of children, medical and

surgical nursing, and other subjects. Public health nursing instructors in universities will find similar opportunities for integrating eye health with units on maternal, infant, preschool, and school health, and industrial nursing. As a staff education project in a public health nursing agency, such a study should stress the relation of eye health to the various existing services which offer opportunity for development of an active eye health program.

Some of the study suggestions have been planned to interest schools of nursing; others, public health nursing agencies. It is hoped that group and individual projects will be developed to enlarge the study further.

APPROACH TO EYE HEALTH PROBLEMS

The protection and promotion of the health of the eyes lies primarily in a recognition of the interrelationship of the whole being. Because eye health is so closely related to mental and physical health, it should receive due consideration in all health, educational, welfare, and industrial programs.

I. NORMAL FUNCTIONING OF THE EYE

A. Anatomy and physiology

A study of eye health should begin with an understanding of the normal functioning of the eye. A review should include: anatomy and physiology; a

consideration of the theories of light, color, form, and depth perception, and fusion; normal refraction and refractive errors; muscle balances and imbalances; normal and abnormal fields of vision. (Ref. 1, pp. 543-557 and 561-565; ref. 2, pp. 1-20 and 84-92; ref. 3, pp. 347-409; ref. 4a.)

B. Light in relation to sight

Adequate and proper light is necessary to eye comfort and efficiency. Light should be:

Well distributed and diffused.

Directed from behind the shoulder line. (When doing hand work, light should be over the shoulder opposite to the hand used.)

Free from glare and shadow.

Adjusted as to the amount needed by the individual for the particular task.

*Miss Mumford is associate for nursing activities, National Society for the Prevention of Blindness, 50 West 50 Street, New York, N. Y.

Glare may be defined as any bright light within the field of vision, reflected or direct. It tends to interfere with visual efficiency, is irritating, and leads to fatigue.

The amount of light needed varies both with the task and with the health and condition of the eye. Intensity is measured in foot-candles; one foot-candle represents the amount of light cast by a standard candle on a surface one foot from the light source. Generally, ten foot-candles are considered the minimum desirable for close work. (Ref. 4b.)

Study suggestions:

Demonstration and practice with a light meter, checking the intensity on the students' own work surfaces.

Review the whole lighting situation in office, classroom, library, patient's room, or students' rooms. Plan for rearrangement to secure adequate lighting. (Ref. 4n; ref. 13, p. 11; ref. 4b.)

C. Nutritional aspects

Until recently the importance of nutrition to eye health has been recognized chiefly in relation to extreme deficiency diseases of the eye which, in this country, are quite rare. However, it is now apparent that deficiencies occur in varying degrees. Inadequate adaptation of the eyes to darkness is believed to be one of the first evidences of vitamin-A deficiency. Since authorities differ as to the reliability of the various methods of determining the state of dark adaptation, there is no uniform agreement as to the prevalence of this symptom. But all agree that vitamin A is essential to normal eye functioning.

While vitamin A is commonly called the ophthalmic vitamin, the B complex and C are also used in the treatment of eye diseases, indicating that they are of importance to the maintenance of eye health. The following are some of the eye disturbances in which vitamins form

part of the therapeutic treatment: (Ref. 6; ref. 2, p. 52.)

Corneal inflammations and degenerations.

Disturbances of choroid and retina.

Toxic amblyopia (especially from alcohol and tobacco).

Inflammations associated with focal infections.

Vascular disturbances.

Night blindness.

Cataract.

Study suggestions:

Discuss the relation of a balanced diet and the maintenance of adequate nutrition to the promotion of eye health. (Ref. 5, 6.)

Review an average day's diet for the adequacy of its vitamin-A content. (Ref. 11, pp. 239-242 and pp. 538-596.)

II. COMMON EYE DISTURBANCES

Eye diseases are frequently named and classified by the part of the eye affected. Thus in ophthalmological texts, keratitis (inflammation of the cornea) will be found under the general heading of diseases of the cornea; iritis, under diseases of the iris; and optic nerve atrophy, under diseases of the nerves.

However, a study of underlying factors leads to the discovery that many eye disturbances may originate in any of several causes.

Example: Etiology of optic atrophy in 523 children: (Ref. 8.)

	Cases
Infectious disease	124
Traumatic injury	38
Toxic agents	3
Neoplasms	46
Noninfectious systemic disease	25
Congenital (cause not known)	126
Hereditary	44
Unknown or not specified	117

For statistical purposes the Committee on Statistics of the Blind recommends the following classification of the causes of blindness by its etiology:

Infectious diseases. (This includes com-

municable diseases—local and systemic—and infections of the eye.)

Trauma, including chemical burns.

Poisonings.

Neoplasms.

General diseases. (These include noncommunicable systemic diseases.)

Prenatal origin. (This includes those of established or presumed hereditary origin and others of prenatal origin where the cause is not specified or not known.)

Etiology undetermined or not specified. (This includes conditions in which the etiology is not known to science or is undetermined by the physician or in which the etiology is not specified.) (Ref. 4v.)

Hereditary or congenital conditions, systemic pathological disturbances, neoplasms, and trauma create serious eye disturbances. Refractive errors may occasionally constitute a serious menace to sight—especially myopia. Muscle imbalances result in a lack of coordination of the two eyes, thus preventing effective use of the two eyes together.

A. Hereditary or congenital eye conditions

Since eye structure is inherited, anomalies can be passed from one generation to another. Hence, two or more similar eye disturbances in a family should be considered suspicious. However, in addition to the cases in which heredity can be established, there is a large group attributed to "undetermined congenital factors." (See also maternal and newborn care, in Part II, to appear in March issue.)

B. Systemic pathological disturbances

Such disturbances are some of the most frequent causes of blindness. Various systemic diseases—communicable and noncommunicable—affect the eye in varied but characteristic ways.

Communicable diseases

Communicable diseases and infections, which in children account for 25 percent of the cases of blindness, include: (Ref. 8.)

Diphtheria

Gonorrhea (exclusive of ophthalmia neonatorum)

Measles

Meningitis

Ophthalmia neonatorum (gonorrheal and nongonorrheal)

Scarlet fever

Septicemia

Smallpox

Syphilis

Trachoma

Tuberculosis

Typhoid fever

Trachoma, an infectious granular conjunctivitis, frequently results in damage to the cornea and scarring of the lids, which interferes with their normal functioning. In the United States, this disease is found in limited areas and among the Indian population. Sulfanilamide is now being used for treatment. (Ref. 3, pp. 122-131; ref. 18.)

Since gonorrhea and syphilis are frequent causes of blindness, it is well to consider how they affect the eyes.

Gonorrheal infections of the conjunctiva, which occur through contamination with infected material or by direct transfer of secretions carrying the organism, result in a purulent conjunctivitis. In the newborn this is called gonorrheal ophthalmia neonatorum. The incubation period varies from twelve hours to three days. Gonorrheal conjunctivitis may result in corneal ulceration, perforation, or involvement of the entire eyeball. Corneal ulcers may leave scars which seriously damage sight, and involvement of the eyeball may result in loss of the eye. (Ref. 3, p. 114.) (See also maternal and newborn care, Part II, to appear in March issue.) Sulfanilamide is now being used in gonorrheal conjunctivitis. (Ref. 19.)

Gonorrheal inflammations may develop in the interior of the eye due to toxins or to metastases. (Ref. 3, p. 488.)

Syphilis gives rise to many ocular disturbances. Primary sores may occur on the lids or conjunctiva. Iritis is sometimes an early symptom of the secondary stage of the disease. Inflammatory conditions frequently occur in

the posterior part of the eye. The tertiary stage creates gummata in the eye tissues and there may be optic neuritis, optic nerve atrophy, and paralysis of both the external and internal eye muscles. Congenital syphilis is frequently responsible for the condition known as interstitial keratitis. (See care of the preschool child, Part II, to appear in March issue.) (Ref. 3, pp. 159-162 and p. 489.)

Noncommunicable diseases

Noncommunicable systemic diseases which commonly affect the eye are:

- Affections of the nervous system.
- Cardiovascular diseases and disturbances.
- Chronic intoxications, including poisoning from alcohol and tobacco, and from chemicals or drugs.
- Diabetes.
- Deficiency diseases.
- Focal infections.
- Nephritis and toxemias of pregnancy.

Each of these diseases causes characteristic manifestations in the eye. For example, diseases of the nervous system may paralyze muscles of the eyes or of the lids; cardiovascular disturbances may interfere with retinal circulation or cause retinal hemorrhages; and deficiency diseases may result in changes in the structure of the eye tissues and—in the case of vitamin-A deficiency—may cause night blindness. (Ref. 3, pp. 479-493.)

C. Neoplasms

Neoplasms may have varied effects upon the eye. Thus, of 89 children in schools and classes for the blind whose blindness was attributed to this cause, the eyeball was affected in 24 cases, the choroid and retina in 5, and the optic nerve in the remainder. (Ref. 20.) Growths in the brain along the optic tract also affect sight in characteristic manner.

D. Trauma

Eye injuries are extremely serious. Penetrating injuries of one eye may

result in a sympathetic inflammation of the other which may terminate in the loss of sight in both. Even a foreign body should be considered dangerous since it may penetrate the cornea or a scratch may result in ulceration and permanent scarring.

E. Refractive errors

In the emmetropic or normal eye, parallel light rays (rays from a distance of 20 feet or more) are brought to a focus at the retina with no accommodative effort. As the object is brought nearer, the rays of light entering the eye are divergent, and to bring these divergent rays to a focus at the retina, the refractive power of the lens must be increased by use of the muscles of accommodation.

The term *refractive error* denotes any condition in which parallel rays of light fail to converge to a focus at the retina or in which such focus can only be achieved with muscular effort. (Ref. 3, p. 362; ref. 4m; ref. 2, p. 88.)

The degree of refractive error is expressed in terms of the strength of the lens (in diopters) needed to correct the error. But full correction is not always indicated, and the prescription may differ from the degree of error found. Correcting lenses are of two types: spherical and cylindrical, each of which may be divergent (concave) or convergent (convex). These will be discussed in relation to the type of refractive error for which they are prescribed.

The types of refractive errors are hyperopia, myopia, and astigmatism. The condition known as presbyopia also creates a refractive error.

Hyperopia

Hyperopia (farsightedness) is a condition in which the length of the eye from front to back is shorter than the distance required to bring parallel rays of light to a focus at the retina, without muscular effort. The resultant blurring

of the image may be cleared by use of the muscles of accommodation. For close work the strain of accommodative effort is increased. Some of the factors which determine the amount of strain involved are

The amount of accommodative power possessed by the eye.

The degree of hyperopia.

The duration of periods of close work.

Convex lenses (plus lenses) are used in hyperopia (and in presbyopia) to shorten the focal length of the light rays entering the eye, thus bringing parallel rays to a focus at the retina with a minimum accommodative effort as in emmetropia. (Ref. 3, pp. 368-374; ref. 2, pp. 88-89; ref. 4m.)

Myopia

Myopia (nearsightedness) is a condition in which the length of the eye from front to back is greater than the distance required to bring parallel rays of light to a focus at the retina. Hence, the point of focus is in front of the retina. No muscular effort is possible to offset this difficulty. Focus at the retina can be achieved only by bringing the object closer—making the rays of light divergent as they reach the eye, thereby increasing their focal length. The length of the myopic eye is due either to its structural shape or to a pathological tendency for the outer coat to stretch—a process which may progress to the point where hemorrhages or degenerations occur. (Ref. 3, pp. 374-379; ref. 2, pp. 89-90; ref. 4m.)

Concave lenses (minus lenses) are used in myopia to spread or diverge the light rays, thus increasing their focal length and bringing the point of focus back to the retina as in emmetropia.

Astigmatism

Astigmatism is any condition in which parallel light rays are not brought to a single point of focus because of irregularities in the shape of the refractive

media, usually the cornea. Because of these irregularities some of the rays of light may focus behind the retina, others in front. The resultant image is blurred and cannot be cleared by any effort of accommodation. Astigmatism is spoken of as hyperopic, myopic, or mixed astigmatism, according to where the principal point of focus occurs. The lenses used for correction of astigmatism are cylindrical and have varying refractive powers in different parts of each lens. A cylindrical lens may have either converging or diverging qualities. (Ref. 3, pp. 380-386; ref. 2, pp. 90-91; ref. 4m.)

Presbyopia

Presbyopia is the term applied to the symptoms of physiological changes in the eyes which become evident about middle age, resulting from a loss of tone of the ciliary muscle and a decrease in the elasticity of the lens. The effect is similar to that of hyperopia. Because of the lack of accommodative power, near vision becomes impossible. As indicated above, convex lenses are used to correct this condition. (See hyperopia.) (Ref. 2, p. 91.) (See also adult health services, Part II, to appear in March issue.)

F. Disturbances involving the external muscles of the eye

Strabismus, crossed eyes, and squint are terms used to denote abnormality in the coördination of the external eye muscles. The origin may be paralytic or nonparalytic. Refractive errors, especially those involving differences in the visual acuity of the two eyes, or absence of the ability to fuse the images seen by the two eyes, sometimes cause the nonparalytic cases. Early discovery and prompt correction of visual defects are essential. Treatment consists of:

Glasses to offset visual defects.

Muscle and eye re-education (called orthoptics).

Surgery on external muscles. (Ref. 4d; ref. 2, pp. 84 and 178.)

Covering the good eye.

CASE-FINDING

Early discovery of eye conditions and of the related underlying causes can best be done by ophthalmological examination in which the physician examines the eye internally and externally and makes various tests of visual functioning. (Ref. 3, pp. 1-10.)

Certain procedures used by such workers as nurses and teachers to aid in the early discovery of those in need of ophthalmological care are commonly called screening procedures. Such procedures include a history of symptoms, the observation of the individual for characteristic behaviors, and tests of vision.

I. SYMPTOMS

Among the common symptoms of eye disturbances are:

- Headache, nausea, and dizziness.
- Pain or irritation in the eyes.
- Disturbances of vision (blurring, double vision, changes in color vision).
- Increased or decreased sensitivity to light.
- Redness of the external part of eyeball or of the eyelids or lid margins.

II. BEHAVIORS

Certain behaviors are so characteristic as to constitute symptoms of eye difficulty. Some of these are:

- Irritability after close work.
- Rubbing the eyes.
- Holding reading matter, toy, or work near or far from eyes to see it.
- Indifference to distant objects or activities.
- Screwing up face when looking at an object or when in bright light.

III. TESTS OF VISION

Tests of vision are used both for screening and as a part of ophthalmological examinations.

A. Snellen test

The Snellen test is the basic test of visual efficiency and consists of reading from a distance of twenty feet a chart of graduated letters, symbols, or numbers

drawn to a specific scale—known as the Snellen scale. The chart requires careful reproduction. To afford ample contrast between the background and the test objects (letters or symbols) the chart must be clean and free from cracks or abrasions, and surface must be free from glare.

The test is given at twenty feet because:

Rays of light are practically parallel from this distance; hence, no accommodation is required by the normal eye. (See above under refractive errors.)

The chart is drawn for use at this distance.

When properly administered and supplemented by careful observations and history, this test is extremely helpful in the discovery of those needing ophthalmological care. (For detailed directions for using this test for screening purposes see reference 4c.)

B. Other tests of vision

Numerous other tests of the visual function are used in ophthalmological examinations, some of which may also be used in screening procedures. These include tests of color vision, tests of muscle coordination, tests of the visual fields, and near vision tests.

C. Tests of color vision

Matching yarn tests such as Holmgren's Test.

Distinguishing colored patterns on colored backgrounds as in Ishihara's Test. (Ref. 3, pp. 335-338.)

(Information about test materials is available from the National Society for the Prevention of Blindness.)

D. Tests of muscle coordination

A simple test which consists of the alternate covering and uncovering of one eye while the other is fixed on a given point may reveal certain imbalances. Watching a subject follow a moving object with both eyes uncovered may show limited eye motions. The use of machines or other more elaborate tests

as screening procedures for determining muscle balance is recommended only under guidance of an ophthalmologist.

E. Tests of the visual fields

Accurate testing of the visual fields is done with an instrument known as a perimeter or with certain types of screens. The purpose of such tests is to determine how much of the area surrounding an object viewed is visible while the gaze remains fixed. In the central part of the field the areas seen by the two eyes overlap. The brow limits the area seen above the object, but to the sides and below, a wider area is visible. Rough estimates of the width of the visual field can be made by bringing a moving object at arm's length forward from the shoulder line until it becomes visible while the gaze remains fixed on a point straight ahead. Approximately all that is forward of the shoulder line lies within the normal field of vision.

Defects of the visual fields are characteristic of certain diseases or abnor-

malities of the eye which interfere with vision in certain areas. Disturbances of the retinal circulation or of the functioning of the nerve endings, or obstructions in the refractive media affect the visual fields. (Ref. 3, pp. 15-20; ref. 2, pp. 77-78.)

F. Near-vision tests

Tests of visual acuity at the reading distance are seldom used in screening since the results are usually about the same as those obtained in the Snellen test, and interpretation of the findings is difficult. (Ref. 3, p. 15.)

The scope and type of screening procedures adopted should be subject to medical approval, including that of local ophthalmological groups.

Study suggestions:

Compile list of observable behaviors which may indicate the presence of visual defects. (Ref. 4c.)

Demonstrate and practice use of Snellen chart for screening purposes. (Ref. 4c.)

STATISTICS ON EYE HEALTH

Because few eye problems are reportable, statistics are meager. Even the amount of blindness can only be estimated.

Blindness is a relative term, ranging from lack of light perception (total absence of sight) to lack of useful vision (20/200 Snellen in better eye with best correction) or seriously defective visual fields.

Estimates of the amount of blindness range from approximately one blind person per 1000 population in the United States based on the 1930 census to a much higher figure which may be nearly twice that. (Ref. 16, p. 254.) From known etiological factors it appears that two thirds of the cases are now preventable.

Statistics on the causes of blindness in children are published annually in the

Outlook for the Blind. (Ref. 8.) Currently studies are being made of the causes of blindness among adult recipients of blind aid, which indicate not only the preventability of blindness but also the fact that many of the applicants for blind aid have remediable conditions.

Etiological factors causing eye defects vary in prevalence in different age-groups and should be studied in conjunction with other health factors related to specific age periods.

Estimates of the prevalence of visual defects (less than blindness) are even more difficult to arrive at because individual ability to tolerate errors varies tremendously. Thus it is difficult to define exactly what constitutes a defect. For the purposes of education, children who have vision ranging from 20/70 to 20/200 in the better eye with the best

correction are usually considered visually handicapped. It is estimated that about one child in 500 is so handicapped.

Studies indicate that seriously defective vision tends to occur with increasing frequency throughout the school years, with decreased prevalence in early adult life (among industrial workers), again increasing greatly in the older age-groups. (Ref. 9.)

Interpretation of studies of visual defects should consider such factors as

Data based on one or both eyes.

Degree of deviation from normal considered to constitute a defect.

Techniques and scope of tests.

Methods of classification.

Study suggestions:

Estimate (a) number of blind in your community, based on the estimate of approximately one per 1000 population (b) number of visually handicapped children in the schools of your community.

Review case records of an eye clinic and classify according to etiology and the extent of visual handicap.

RESOURCES

Eye health is influenced by such diverse factors that no one agency or professional group can be responsible for all the factors involved. Standards affecting eye health are formulated by such groups as:

The medical profession through groups of ophthalmologists.

Illuminating Engineering Society.

American Institute of Architects.

National Safety Council.

Committee on Statistics of the Blind.

The approach to a well rounded eye health program is through the coordination of the activities of the agencies conducting health, welfare, educational, and industrial programs.

I. NATIONAL RESOURCES RELATED TO EYE HEALTH

The National Society for the Prevention of Blindness is a voluntary organization providing leadership to the prevention of blindness movement and helping to coordinate eye health activities. Its staff represents several professions concerned with eye health. It publishes a quarterly magazine, *Sight-Saving Review*, and other publications. It supplies exhibits and other educational material to local agencies. It serves as a bureau of information on eye health.

The *Federal Security Agency* makes grants to states for financial aid to the

blind and for remedial treatment for applicants for blind aid, and develops standards for blind assistance. These functions are conducted through the Social Security Board.

Certain services provided by other federal bureaus indirectly affect eye health. Some of the important ones are:

The syphilis and gonorrhea program of the United States Public Health Service.

The maternity and infancy program of the United States Children's Bureau.

The standardization of safety devices and the testing of certain equipment by the United States Bureau of Standards.

II. STATE AND LOCAL RESOURCES RELATED TO EYE HEALTH

Although all general health programs contribute indirectly to eye health, certain functions of various state and local agencies contribute very definitely to the protection of the eyes. The relationship of several types of agencies to the eye health program is indicated below.

Commissions for the blind (sometimes a division in the department of welfare). The usual services rendered are financial assistance to the blind—including remedial treatment for applicants for blind aid—and education and rehabilitation of the blind. In some states, diagnostic clinics and educational services for the visually handicapped are included.

Financial aid for the correction of visual defects may be under the commission or under the welfare department. The crippled children's service sometimes provides aid for eye surgery for children.

Departments of education. Functions which contribute directly to eye health include the development of regulations concerning school lighting and construction; and provision for special educational facilities for visually handicapped children.

Health departments. Functions which contribute directly to eye health include the prevention and control of ophthalmia neonatorum; of trachoma; and of systemic communicable diseases which frequently affect the eye, such as syphilis, gonorrhea, measles, scarlet fever, or meningitis.

Industries. Some of the responsibilities for eye health of the employees which are commonly accepted by industries include periodic eye examinations, provision of safety equipment, and first-aid service.

Departments of labor. Functions which contribute directly to eye health include developing and administering safety and lighting codes for industries

and the administration of compensation for industrial eye injuries.

Schools. Some of the responsibilities for eye health of school children which are commonly accepted by the schools include the provision of an environment favorable to eye health and safety; the adaptation of educational practices to the eye health needs of the children; the education of children to desirable practices in the care and use of the eyes. (See also the child of school age and school health services, Part II, which will appear in March issue.)

III. PRIVATE AGENCIES

In a few states, societies for the prevention of blindness have been formed. Their primary function is educational, although in some instances direct services are rendered to individuals or individual patients, usually in coöperation with local agencies.

Study suggestions:

Compile a resource file for your own state and community, including resources for eye care, and financial, educational, and social services for the visually handicapped.

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(To be continued)

Delivery Nursing in Rural Homes

The rapid development of rural home delivery nursing services raises many questions as to the practicability of such a service and the details of its administration. The following conclusions in an article by Marian Sheahan on two rural services in New York State ("Maternity Nursing in Rural Homes") published in the *Milbank Memorial Quarterly* for April 1938, are of special interest at this time.

While no definite conclusion can be drawn, a few general comments might be made based on these two experiences as they have progressed to date.

The character, geography, population distribution, and the social and economic situation in counties will simplify or complicate the provision of a delivery service more acutely than do these same situations in relation to other services.

It is reasonable to believe that there may be certain county situations where a delivery service could not be arranged for an entire area with . . . economy.

The utilization of private duty nurses appears entirely feasible but not as easily secured as might be thought.

The integration of delivery service in a generalized service is practicable if the necessary adjustments can be made and controlled.

The emergent nature of the service requires more staff, or some certain way of assuring sufficient nurse power to keep pace with the growing demands for assistance at delivery.

It appears necessary to arrange for an adequate budget to take care of such overhead as complete telephone coverage, necessary nursing relief, and for more administrative supervision than is necessary in a service which lends itself to routine. From a nursing point of view, this seems the crux of the situation as far as administration and economical use of nursing power are concerned.

The integrity of the generalized service, other than delivery, can only be

safeguarded if the above administrative overhead is provided for. The very nature of a delivery service gives it preference in the list of services.

From the data available to date it is reasonable to believe that a delivery service is an important—if not the most productive—service in securing family and medical coöperation in maternal and child care. It appears to influence favorably the possibility for more and earlier antepartum supervision and improvement in infant hygiene following birth of the baby.

There is reason to believe that nursing assistance at deliveries is an important factor in assuring a relatively clean, if not an aseptic delivery in most of the homes.

Nursing care of the mother during the entire labor period is in demand. It seems possible to provide it.

While actual costs are not yet available, it appears the case cost, even though high, is a reasonable public expense when all the factors surrounding the loss of a mother are considered.

For the most part the nurses themselves quickly become interested in the delivery service even though their first reaction may be to object to a service which implies certain restrictions of their usual free time. It is evident that staff morale can be maintained if reasonable compensation is provided. Compensation in extra time appears to be satisfactory. (A cash bonus arrangement has been suggested but cannot easily be worked out in civil service.)



SAVANNAH INTERPRETS ITS NURSING SERVICE

These two exhibits were prepared by the Savannah Health Center, a joint official and nonofficial public health nursing service, for the meeting of the three state nursing organizations in Savannah, November 13 to 15, 1939. The top exhibit in miniature was displayed at the Hotel DeSoto, where the meetings were held. The lower exhibit on maternal education, with life-sized figures, appeared in the window of a department store.



News from the S.O.P.H.N.'s

THE New Jersey S.O.P.H.N. is an active and busy organization. Its board of directors—which includes elected members, chairmen of committees, and chairmen of sections—holds regular monthly meetings. These meetings never lag in interest because of the many active committees which make the S.O.P.H.N. an integral part of all public health activities and progress in the state. As occasion offers, persons outside of the board are invited to attend meetings and present their field of interest or participate in discussions.

Representatives from the State Nurses' Association, the State League of Nursing Education, and the State Board of Examiners of Nurses are *ex officio* members of the board without a vote, and they rarely miss a meeting. The value of this participation to all the organizations concerned cannot be overestimated.

The Organization keeps abreast of current progress and opportunities in the state through committees which are advisory to other statewide organizations or departments, such as the Old Age Assistance Division, Department of Institutions and Agencies, and The New Jersey Health and Sanitary Association. There is a Subcommittee on Public Health Nursing of the Governor's Committee on Health and Welfare. The Public Service Committee—representing the three state nursing organizations—is advisory to the Civil Service Commission.

Members serving on committees have assisted in the Crippled Children Commission in setting up standards; selecting applicants; and working out a program for payment to public health nursing agencies for services to crippled children, from the available federal funds in the state. Plans are under way for

courses in orthopedic nursing, the result of the work of this committee in close coöperation with the Commission.

One S.O.P.H.N. representative serves on the Council on Advisory Public Health Nursing Service, which is advisory to the committee in the State Board of Health that is responsible for developing this service, defining functions, and working out standards. In 1938 the S.O.P.H.N. requested an advisory public health nursing service in the State Department of Health and it has worked closely with the committee directly responsible for the service since its establishment.

Through its representatives on these groups, the S.O.P.H.N. is given the opportunity to render assistance to social and health programs in various ways, and it is in turn better qualified to interpret to its own group the objectives of agencies with allied interests.

The work of the Social Hygiene Committee, which is affiliated with all other state activities in this specialty, is outstanding. A manual for nurses is now under preparation through the joint efforts of these groups.

Some of the Organization's specific accomplishments include assistance in (1) establishing standards (2) selecting the best applicants for important posts (3) interpreting the needs of public health nursing to official agencies.

Over a period of years an excellent spirit of understanding with the medical profession has been developed through coöperation with the state medical society. The knowledge that any questions or problems will receive consideration at an unbiased council table has eliminated misunderstandings which would hinder progress.

The preparation of a history of public health nursing in New Jersey which is now underway brings every organiza-

tion and department concerned with health into participation, and all may make their contribution. This history is being prepared as an activity of the Lay Section.

An endeavor is being made to find a way in which public health nursing may be promoted through the coöperation of the State Department of Health, in order not only to supply a need to some communities but to pave the way for closer coördination between public and private agencies. The Lay Section has offered its assistance in a coördinated plan to establish a generalized public health nursing service in an isolated area which does not at present have such a service.

The School Nursing Section has provided programs of great value to school nurses, often jointly with the educational organizations of the state. Special committees are studying standards for school nurses. An institute for nurses in high schools is planned for 1940.

The S.O.P.H.N. has received help with many of its activities from the National Organization for Public Health

Nursing, to whom state sections and committee chairmen constantly turn for assistance and suggestions.

The whole membership of the State Organization for Public Health Nursing needs to be more aware of the many accomplishments on their behalf. Because of modesty on the part of those actively engaged in the work and the fact that publicity may sometimes defeat the purpose of an undertaking, public health nurses sometimes do not realize what is being accomplished for them as individuals. While the membership showed an increase of 96 new members in the first nine months of 1939, the S.O.P.H.N. will not be content until public health nurses and lay people representing the various public health interests in the state take the initiative in becoming members. We believe that day is not far distant and on our twenty-fifth anniversary in 1940 we welcome a new awareness to the work of the State Organization for Public Health Nursing.

NELLIE OGILVIE, R.N.

*President, New Jersey State
Organization for Public Health Nursing*

Your N.O.P.H.N.

THE PURPOSE of the statistical service of the National Organization for Public Health Nursing is to serve public health nurses by organizing information in a concise form. Tables are often used because they can show information about a large number of anything, at one glance.

Tables do seem to make up most of the furniture of a statistical office. Our files of your Yearly Reviews are, however, the basic material for most of the tables. Yearly Reviews—and we spell them with a capital Y and capital R—are three- or four-page schedules about policies in public health nursing agencies. We receive one schedule from each

agency. In the Yearly Reviews returned in the spring of 1939 by the directors of almost six hundred agencies we have data about staffs, salaries, salary increases, income, clerical workers, fees charged for visits, student affiliation, and changes in program. From the replies in your Yearly Reviews we are sometimes able to picture the situation in your city or area that explains the question in your letter and possibly this gets you a more sympathetic and satisfactory answer.

These schedules from agencies are in almost constant use, not only by the statistical service, but by all members of the N.O.P.H.N. staff. They are kept according to the year in which they are

received, and indexed according to the type of agency. A code system shows further classifications. By *code* we mean the assigning of letters or numbers to various classifications. We code the Yearly Reviews according to geographical location, size of the population, and number of nurses employed.

A three-by-five-inch card for each organization shows the years for which we have a Yearly Review from that agency, and in addition—in code—the type of agency, geographical location, size of staff, number of nurses receiving high or low salaries, and sources of income.

One of us the other day sat here talking with a director about her agency, giving her comparative information from several similar agencies, using a dozen or so of these three-by-five cards. Reading and comparing the data from these concisely coded cards, the statistical worker looked almost like a fortune-teller. If you are interested in such devices—and statistics is not all drudgery if devices like this work out—try out a card system in your next agency study or for your next project at the university.

From the Yearly Reviews we are able to present nationwide studies about public health nursing agencies. One on income was published in the January 1940 issue of *PUBLIC HEALTH NURSING*. (Page 39.) Once the tables are put together, they afford answers to many questions. Besides the material published, there are additional tables that do not seem to have enough value to be printed, at least for general use. These are, however, helpful to all of us in understanding trends or specific situations. They are available in typewritten form to any public health nurse, but we have to ask that they be returned in order to save the cost of copying them too often.

In addition to material from the Yearly Reviews we have special statistical projects under way. One of these has involved the reading of many tuber-

culosis case records in the attempt to learn methods of studying case records so as to improve quality of service. This is research of a different kind. But the same technique of making schedules, analyzing and coding the information, tabulating data, and writing reports is followed. Special projects go more slowly than the regular studies and require much more committee time and discussion.

We have the schedules of previous studies and these often help in answering your questions. When other staff members are making studies involving statistical procedures they often bring their material to us for advice.

We help them whenever problems of community studies call for calculations or graphs or comparable data from other cities. And by the way, we can make arrangements on occasion to visit you in your office to help with your record and reporting systems.

We try to keep copies of published studies—besides our own—about public health nursing and closely allied subjects. Among these allied subjects are hospital studies, clinic studies, nutrition program material, and medical social case-work publications. We even try to keep a few jumps ahead by noting studies now in progress, in what we call a clearing house for studies. Reports and information about these current studies are available to any public health nurse. In learning about new studies the National Health Library on the floor above us is indispensable, particularly through its periodicals—of which it receives 500 a month. We are a supporting member of the Library, and therefore its collection of books, pamphlets, and reprints is available on a loan basis to any member of the N.O.P.H.N.

Returning from the Library, let us look around the statistical office again. There sits a Monroe Calculator, the answer to a statistician's prayer. Now if you could be sure that every per-

centage, every rate, every set of additions is correctly calculated, wouldn't it make statistical procedures less formidable? The Monroe takes care of all arithmetic that can be mechanized. If we can be sure of the accuracy of the original data—and that is a primary responsibility in the statistical field—the Monroe must produce the correct answers if we press the right keys.

Drawing of graphs is part of the work of a statistical service. To me the first draft is usually the most interesting—certainly the most individualistic. The last graph that we made showed the professional qualifications of a representative group of some thousand public health nurses. Lantern slides were made of this set of graphs for use at state nursing meetings. Possibly we should be preparing more graphs. What are your interests and wishes about this?

YOUR COMMITTEES

One way we learn of your wishes currently is through committees. The Records Committee and the Committee on Cost Analyses are two groups which have been very active in studying statistical problems. Other committees have also invited members of the statistical service to meet with them. There are 46 individuals who are members of these groups dealing with statistical problems. Some of the 46 are on more

than one committee. The majority are public health nurses. There are, however, board members, physicians, and five research workers among them. Discussions at the committee meetings keep one in touch with the experience of agencies and with concrete situations. Through them we feel less remote from the ultimate purposes of public health nursing. The decisions of the group formulate the policies under which we all work. While it is just impossible to make short summaries of minutes of committee meetings, paragraphs from them are often used when we reply to your requests for composite points of view.

There seems to be a great deal here about answering your requests. It is true that a good part of our time does go into letter writing. Will those of you who have not used the statistical or library facilities of the N.O.P.H.N. since you became members please raise your hands? We are here, paid for in great part by your membership dues, to help with studies of public health nursing. This description attempts to show what equipment we have. We hope you will continue to find it serviceable.

DOROTHY E. WIESNER
Statistician

This is the sixth of a series of articles on the National Organization for Public Health Nursing, written by the president and members of the staff.

MORE LAY PEOPLE IN HEALTH AGENCIES

A RECENT census of volunteers in 100 Detroit agencies shows that the medical and nursing agencies lag far behind the other social agencies in using lay people. The study was made by the Central Volunteer Council of the Council of Social Agencies.

The total number of volunteers, including board members, was 20,330. This was broken down into the follow-

ing groups: board members, 11.3 percent; committee members, 36.8 percent; and volunteer workers or personal service, 51.9 percent.

The analysis by function shows the following distribution: case-work agencies, 15.3 percent; group work agencies, 54.3 percent; planning and fund-raising agencies, 23.9 percent; and medical and nursing agencies only 6.5 percent.

NOTES *from the* NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

HONOR ROLL

The first 1940 Honor Roll list will be published in the March issue of **PUBLIC HEALTH NURSING**. Every nursing service—whether staffed by one nurse or one hundred—is eligible for Honor Roll listing and a Certificate when each nurse has joined the N.O.P.H.N. for 1940.

We have already begun to send out Certificates as a reward for the continued loyalty and support of the agencies with 100 percent enrollment and we hope that more Certificates than ever before will be issued during 1940!

The Honor Roll list is not cumulative during the year. Each month the magazine will publish the names of those agencies whose staffs have attained Honor Roll standing since the previous list appeared.

Don't forget to let us know just as soon as you are eligible!

WITH THE STAFF

Dorothy Deming, Ruth Houlton, and Purcelle Peck attended the White House Conference on Children in a Democracy in Washington, D.C., January 18 to 20.

Ruth Houlton spent the first week of January in Minneapolis and St. Paul, Minn., visiting the nursing services in both cities and speaking before a group of industrial nurses in Minneapolis. She was in Chicago, Ill., on the fifth and sixth conferring with members of the staff of the National Safety Congress, the American College of Surgeons, and the Infant Welfare Society.

Evelyn Davis attended the board meeting of the Visiting Nurse Association in New Brunswick, N. J., on December 20. She held a board members' institute under the Council of Social

Agencies in Pittsfield, Mass., on January 24.

Jessie Stevenson conducted institutes on orthopedic nursing in Indiana, January 3 to 6, and in Iowa, January 9 to 12. She spent January 16 to 19 in West Virginia on an observation trip.

Dorothy E. Wiesner attended the annual meeting of the American Statistical Association which is celebrating its hundredth anniversary on December 28 and 29 in Philadelphia, Pa.

REGISTER EARLY

Registrations for the group conferences to be given at the Biennial Convention will be accepted in order of application and notification of acceptance will be sent as promptly as possible. The group conference on orthopedic nursing has been made possible as a part of the special project in orthopedic nursing financed by the National Foundation for Infantile Paralysis. Therefore, no registration fee will be charged for this conference. Refer to your January issue of **PUBLIC HEALTH NURSING** for the details concerning the group conferences. The closing registration date is April 15.

WHAT TO WEAR AT THE BIENNIAL

On May 12, summer will be just around the corner in Philadelphia. It is possible that you may be quite comfortable in your spring suit or light dress, but you will be wise to have a top coat with you, for chill winds and showers may turn up unexpectedly. Comfortable shoes are important in case the spring weather tempts you to walk to and from the convention hall.

RAIL RATES TO THE BIENNIAL

The following are round-trip, first-class fares from principal points in the United States to Philadelphia:

	30 days	Lower berth one way
Oklahoma City, Okla., via St. Louis	\$70.00	\$11.85
Tulsa, Okla., via St. Louis	67.40	11.35
Fort Worth, Tex., via St. Louis	70.25	12.35
Dallas, Tex., via St. Louis	68.95	12.35
San Antonio, Tex., via St. Louis	80.05	14.70
Fort Smith, Ark., via St. Louis	61.45	10.80
Kansas City, Mo., via St. Louis	64.85*	1.05 Seat to St. Louis 7.65 Lower beyond
St. Louis, Mo.	52.30*	7.65
Springfield, Mo., via St. Louis	63.10*	10.30
Memphis, Tenn., via St. Louis	53.45	10.30
Memphis, Tenn., via direct route	50.10	8.40
Birmingham, Ala.	42.45	7.10
Atlanta, Ga.	36.70	6.05
Nashville, Tenn.	40.75	6.30
Boston, Mass.	21.00	1.60 Seat
	16.20**	
Chicago, Ill.	44.70	5.80
	28.75**	
Denver, Colo., via St. Louis	91.30*	13.40
Jacksonville, Fla.	43.50	7.35
Minneapolis, Minn.	63.05*	8.40
New Orleans, La.	58.50	9.45
New York, N. Y.	5.40	.55 Seat
	4.05**	
San Francisco, Calif.	135.00	22.05
Seattle, Wash.	139.40	22.05
Washington, D. C.	7.95	.80 Seat
	5.95**	

*Tickets having a 60-day limit.

**Deluxe coach fare.

TRANSPORTATION CHAIRMEN

Nurses and laymen who are planning to attend the Biennial Convention may obtain information about railway transportation by writing to the chairman on transportation in their state.

Mrs. Lillian H. Smith, Executive Secretary, State Nurses' Association, 625 South Lawrence Street, Montgomery, Ala.

Minnie C. Benson, Secretary, State Nurses' Association, 210 Southern Arizona Bank Building, Tucson, Ariz.

Mrs. W. I. Scott, 900 East 8 Street, Little Rock, Ark.

Irene Murchison, Executive Secretary, State Nurses' Association, 621 Majestic Building, Denver, Colo.

Margaret K. Stack, Executive Secretary, State Nurses' Association, 252 Asylum Street, Hartford, Conn.

Edith M. Beattie, Executive Secretary, District Nurses' Association, 1746 K Street, Northwest, Washington, D.C.

Mrs. Erma Mitchell, State Board of Health, Jacksonville, Fla.

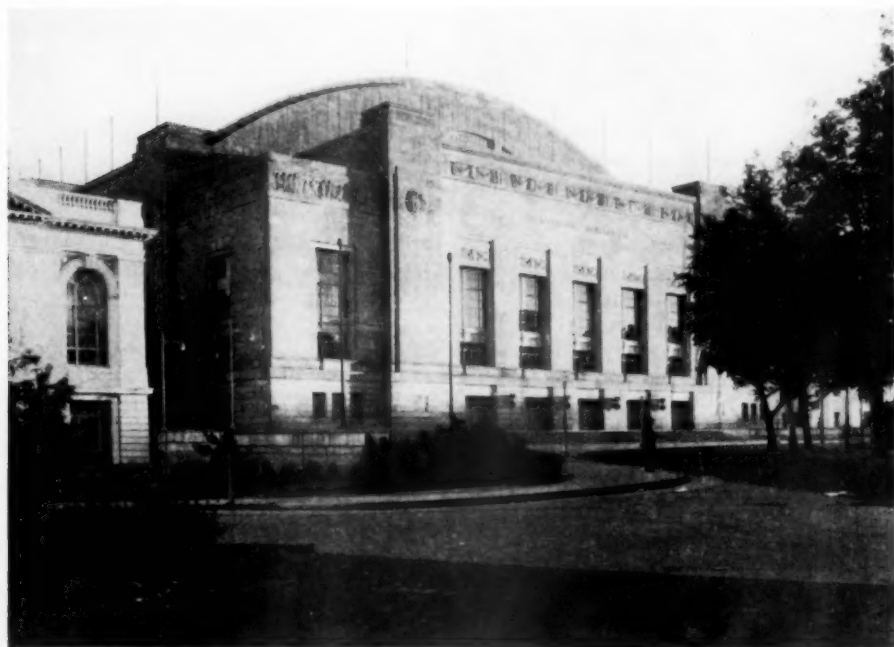
Durice Dickerson, Executive Secretary, State Nurses' Association, 131 Forrest Avenue, Northeast, Atlanta, Ga.

Helen Teal, Executive Secretary, State Nurses' Association, 1125 Circle Tower, Indianapolis, Ind.

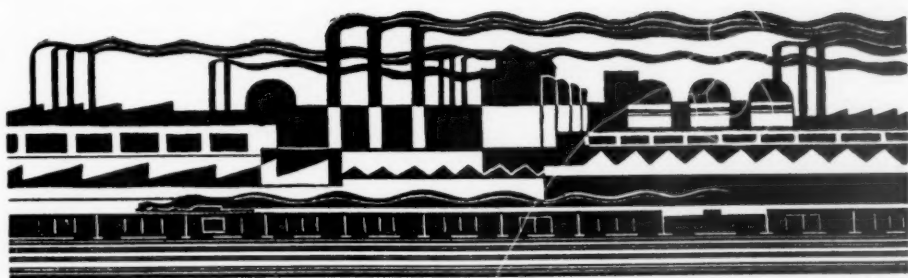
Alma E. Hartz, State Department of Health, Des Moines, Iowa.

Mrs. Anne Lee Wick, Secretary, State Nurses'

- Association, 359 North Clifton, Wichita, Kans.
- Mrs. Alice S. Hawes, Executive Secretary, State Nurses' Association, 54 Saunders Street, Portland, Maine.
- Mrs. Blanche G. Powell, Executive Secretary, State Nurses' Association, 1217 Cathedral Street, Baltimore, Md.
- Helene G. Lee, Executive Secretary, State Nurses' Association, 420 Boylston Street, Boston, Mass.
- Olive Sewell, Executive Secretary, State Nurses' Association, Capitol Savings and Loan Building, Lansing, Mich.
- Caroline Rankiellour, General Secretary, State Nurses' Association, 2642 University Avenue, St. Paul, Minn.
- Mary E. Stebbins, Executive Secretary, State Nurses' Association, 1101 Waldheim Building, Kansas City, Mo.
- Wilkie Hughes, Executive Secretary, State Nurses' Association, 17 Academy Street, Newark, N.J.
- Emily J. Hicks, Executive Secretary, State Nurses' Association, 152 Washington Avenue, Albany, N.Y.
- Edna Heinzerling, Executive Secretary, State Nurses' Association, 417 Commercial Building, Raleigh, N.C.
- Mrs. Edna Schneider, 518 Tenth Street, Bismark, N.D.
- Mrs. E. P. August, Executive Secretary, State Nurses' Association, 50 East Broad Street, Columbus, Ohio.
- Mrs. Charlotte Oderkirk, Secretary, State Nurses' Association, 1124 South Florence Avenue, Tulsa, Okla.
- Mrs. Linnie Laird, Executive Secretary, State Nurses' Association, 301 Stevens Building, Portland, Ore.
- Esther Entriiken, General Secretary, State Nurses' Association, 400 North Third Street, Harrisburg, Pa.
- Annie M. Earley, Executive Secretary, State Nurses' Association, 381 Angell Street, Providence, R.I.
- Nina E. Wootton, Executive Secretary, State Nurses' Association, 414 Cotton States Building, Nashville, Tenn.
- A. Louise Dietrich, General Secretary, State Nurses' Association, 1101 East Nevada Street, El Paso, Tex.
- Rita Ercanbrach, Salt Lake County General Hospital, Salt Lake City, Utah.
- Mrs. Jessie Wetzel Faris, Executive Secretary, State Nurses' Association, 811 Grace-American Building, Richmond, Va.
- Mrs. C. D. Partridge, Executive Secretary, State Nurses' Association, 3727 East Layton Avenue, Cudahy, Wis.
- Mrs. Henrietta Schunk, 620 Illinois, Sheridan, Wyo.



Municipal Auditorium, Philadelphia, where the Biennial Convention will be held May 12-18



WHAT HOURS DO YOU WORK?

WHAT HOURS should the industrial nurse work? There are various points of view on this question, and the answer will depend on the needs of the individual plant.

The nurse is in the plant for the protection of the workers' health so that production will go on without delay. One important factor to be considered in determining her hours of work is the value of having her on duty to see workers who have been absent because of disability.

Workers returning to work after absence due to sickness or an accident should be seen by the nurse or medical director before being allowed to work. Perhaps in a large number of plants this routine is not carried out, but it is a paying procedure. Most plants start their day at 7:00 or 8:00 a.m. If the nurse works from 7:30 to 4:30, with her lunch hour from 12:00 to 1:00, she is there early in the morning and is able to take care of employees before they leave the plant at the end of the day.

The following examples will show the value of having the nurse on duty to readmit absentees.

When Mary Smith came back to work after being absent a week she was asked if she had seen a physician. She said that she had, and that her doctor knew she was working. Since the girl did not look well, the nurse called the doctor to ask about her condition. He replied

he thought she was at home—where she belonged.

John Brown returned after being away from work for three days with a cold. He said he felt fine and able to work. The nurse took his temperature and found it to be 100° F. at 7:30 in the morning. He was sent home until he had recovered and was really fit to work.

Joe Martinelli returned to work stating he had been absent on account of a sore throat. He said that his throat was all right and he was able to work. The nurse took his temperature, which was 100° F. She looked at his throat, and saw that his tonsils were badly inflamed so that he could barely swallow. Obviously he should not be working either from the standpoint of his own health or that of his fellow workers.

May Black returned to work and reported that she had been absent due to pain in her abdomen. She said she felt able to work. The nurse upon questioning her learned that the pain was in her lower right side. She had a temperature of 99.6° F., and had been vomiting. She was sent home with the admonition to see a doctor at once. Later the nurse learned that she had had an operation for acute appendicitis four hours after leaving the plant.

These are illustrations of the value of having the nurse check in all employees who have been absent due to sickness or accidents. A nurse working from 7:30

to 4:30 is on duty in good time to see all these people before they work, and the worker is not kept waiting long. It is part of the nurse's job to see these employees. Moreover, because of unemployment insurance, group health and accident insurance, and compensation insurance, this readmission procedure is important. These hours are also useful for dressings and redressings. In plants where the nurse interviews new employees before they are hired, the same hours will prove satisfactory for such conferences. After all, there is no advantage in having the nurse work the same hours as office employees, since she is directly connected with the plant and her time should be planned in relation to that of the workers.

Absentee records are very important and absentee cards should be used. When an employee is absent, his regular time card is replaced by an absentee card—which is the same size as the time card—and his regular time card is sent to the nurse. When he returns to work this card is filled out by the nurse, at which time she also checks him back.

Facts concerning absences, accidents, and illnesses are important. When the same person is responsible for checking all absences it is possible to determine easily whether one department is having more absences than another. If this is the case there must be a reason. Absences sometimes show hazardous conditions of employment that should be

corrected. Physical disability among workers, whether they result in absences or not, is a costly factor which results in underproduction, spoiled goods, and labor turnover. Men or women on the job who are not physically fit to work make sick factories, offices, and stores. It is important for both the plant and the worker that employees shall not work unless they are in satisfactory physical condition.

Any employee who has been absent and who has seen a doctor should be required to bring a physician's certificate of health stating that his condition is satisfactory for him to be doing his regular work. Any employee whom the nurse sends home or about whose condition she feels in doubt should also secure a physician's statement.

If new ideas are to be carried out in relation to safety and health, the people interested must be there at the time when they are most needed for the health program. The nurse's hours of work should be planned so that she can give the best possible service for the protection of the workers' health, and hours which will make possible a careful check-up on the health of returning absentees will be of inestimable value to the plant.

ADELE B. SCHOOF, R.N.

*J. Greenebaum Tanning Company
Milwaukee, Wisconsin*

NOTE: Readers are invited to express their ideas about the hours of work which they believe are most useful for good health service to the worker.

WHO'S TOO SMALL?

A PAMPHLET on the question "Who's Too Small for a Health Program?" has been prepared by the Committee on Healthful Working Conditions of the National Association of Manufacturers, 14 West 49 Street, New York, N.Y. This concise little leaflet answers the question so frequently asked, "Can my plant afford a health program?" Plant managers, citizens interested in better industrial health, physicians, and nurses will find it a useful reference.



A TEXTBOOK OF PRACTICAL NURSING

By Kathryn Osmond Brownell. 418 pp. W. B. Saunders Company, Philadelphia, 1939. \$3.

Those who believe that the practical nurse will always be with us and can be trained to meet a definite need under certain conditions of illness in the home will be interested in this new textbook. The problem of training the practical nurse to meet the standards set by the law in New York State calls for textbooks in this field, which at present are scarce. Miss Brownell's contribution is therefore a timely one.

The contents of the book are well arranged. At the end of each chapter there are questions for study and discussion, a short true-and-false type of examination which is a good self-check on the student's knowledge of the chapter, and a bibliography which should be useful to the instructor and the more inquisitive type of student.

It is hard to understand why treatments that are usually ordered in the more serious type of illness and which require expert nursing should be included in a book for the practical nurse. One has a shock when reading the following directions for filling a hot water bottle: "Fill the bag a scant one-third full of boiling water." It is assumed this is an error that slipped by the author in checking the material, for the serious consequences of such a procedure are all too obvious.

The chapter on Growth in Children would be improved in places with the use of more up-to-date information. Since authorities agree that the attitudes and habits acquired in this period influence a child all through life, it is too bad that this chapter does not discuss more fully some of the common problems of this

age and acceptable methods for meeting them.

The book on the whole has much useful material, and as the training courses for the practical nurse become more numerous this text will fill a real need and give valuable assistance to both instructor and individual students.

ELIZABETH CURTIS, R.N.
East Orange, New Jersey

AN INTRODUCTION TO SOCIOLOGY AND SOCIAL PROBLEMS

By Deborah MacLurg Jensen. 341 pp. The C. V. Mosby Company, St. Louis, Missouri, 1939.

The preface states that this textbook is designed to meet the needs of those courses in sociology and in social problems that are outlined in A Curriculum Guide for Schools of Nursing.

Section I covers the general phases of sociology, such as the development of man's social behavior, the collective behavior of man, the development of the community (with a chapter on what the nurse should know about her own community), the family, and present-day trends in social change. In Section II, social problems, particularly those involving health matters, are presented.

The format of the book has teaching value in health. The print is somewhat larger than is usually found in textbooks, and the paper has a dull finish, off white.

This text would be a valuable guide to instructors in sociology who do not have a preparation in nursing, in schools where nursing students are not required to have the beginning course in sociology that is presented in most universities.

KATHLEEN M. LEAHY, R.N.
Seattle, Washington

RURAL MIGRATION IN THE UNITED STATES

By C. E. Lively and Conrad Taeuber. 183 pp. Research Monograph XIX, Works Progress Administration, Division of Research, United States Government Printing Office, Washington, D. C., 1939.

This timely publication clarifies the problem of migration, by uncovering many of its ramifications. The rural migrant (farm or nonfarm, individual, or family) is but one character in the tragedy. The place of emigration, the environment where resettlement is attempted or occurs, and regions dependent upon seasonal labor or immigration play equally important roles. Secondary consideration is given to problems arising when "usual" migration fails to occur. The many tables and charts find an excellent summary in the photographs (page 82) entitled: Some move East while some move West. Contrary to popular belief, this type of social mobility, although profoundly affected by present conditions, is characteristic in the life history of the American people.

Indicating few remedies, the study leaves no doubt that only extensive planning can hope to bring these national currents into productive channels.

GERTRUDE ZURRER, R.N.
West Haven, Connecticut

THE STORY OF A BABY

By Marie Hall Ets. 63 pp. The Viking Press, New York, 1939. \$2.50.

The Story of a Baby is especially significant for the illustrations by the author depicting, in clear pencil diagrams, the growth of the baby from a tiny cell through the various embryonic stages to birth. Any child would be fascinated by this accurate story in pictures of his early development. It includes charming sketches of the newborn baby, sleeping, yawning, crying, and gazing up at the reader in a very lifelike manner. The book also contains illustrations of cavemen, legendary ancestors, whales, and various other forms

of life, to emphasize the universality of the growth process through the ages.

The narrative part of the book seems slightly confusing, however. A seven-year-old kept interrupting her mother to say, "What does that mean? What is the stuff of life?" The author attempts to tell too much. The factual material is vaguely worded and over the heads of children. It seems more suitable for the first-year medical student.

The book is, however, well worth owning for its illustrations alone and is a distinct contribution to the field of sex education.

HELEN FIRMAN SWEET
Fairfax, Virginia

LOVE AT THE THRESHOLD

By Frances Bruce Strain. 349 pp. D. Appleton-Century Company, New York, 1939. \$2.25.

Mrs. Strain will be known to many nurses for her previous publications in the field of sex education. In *Love at the Threshold* she brings to adolescents and their counselors her intelligent and refreshing view of the problems of social customs, dating, love, and marriage.

There is humor and charity, as well as deep understanding, in Mrs. Strain's approach. Dating is given the dignity and importance it deserves as a preliminary for more serious attachments. Marriage is presented as an adventure in living, tremendously important, and worth careful thought. With great diplomacy she interprets to the adolescent, not only his own hopes and fears in relation to heterosexual adjustment, but also the attitudes of parents.

Throughout the book it is emphasized that relationships in love are inextricably interwoven with other social attitudes. Important and nonimportant matters are separated skillfully, as indicated in the discussion of slang. "If you use slang at all," says Mrs. Strain, "it must be current, fresh, and crisp as lettuce, and thrown out the minute it begins to droop." Chivalry is brought

up to date with a concrete example. A gentleman is "one who will come to the rescue of a girl in a stalled car without making her feel that no woman knows how to drive properly."

Good judgment and careful thought to the consequences, rather than mere observance of the conventions, are given emphasis in relation to sex experience outside of marriage. Practical suggestions are given for substitutes for petting, and for keeping petting within desirable bounds.

The chapters on the consummation of marriage and childbearing are handled with delicacy and good sense. The questions of birth control, "painless delivery," and syphilis are introduced skillfully, and in a positive, helpful manner.

This book should be an invaluable addition to the library of the public health nurse, both as a guide to the adolescent and his problems, and as a practical handbook on sex education for that group. It may be recommended to parents and adolescents without reservation.

RUTH FREEMAN
New York, New York

DYSMENORRHEA

By Albert A. Davis, M.D. 254 pp. Oxford University Press, New York, 1938. \$4.50.

This is a concise but comprehensive little book dealing exclusively with a symptom, not a disease. The author has correlated the views and experiences of outstanding gynecologists to justify his presentation of an authoritative consensus, although his personal beliefs and therapeutic preferences are freely expressed. The various aspects of pain associated with menstruation are systematically described, and due attention is accorded the causes and prevention of dysmenorrhea, as well as its treatment.

Dr. Davis ascribes the origin of menstrual pain to neuropathological factors in the majority of cases, and is an enthusiastic advocate of alcohol infiltra-

tions of the "pelvic nerve plexus"—a procedure little used in this country. He also favors hormonal therapy and presacral sympathectomy in certain cases. Nevertheless, constitutional, physiotherapeutic, medicinal, and radiological treatment are adequately described without prejudice. This will enable the physician to select whichever therapeutic method he deems indicated in an individual case.

WALTER T. DANNREUTHER, M.D.
New York, New York

WHEN SOCIAL WORK WAS YOUNG

By Edward T. Devine, Ph.D. 163 pp. The Macmillan Company, New York, 1939. \$1.75.

Current social work is too frequently seen as wholly new with no "direct historical ancestry." Beginning with the '90's, Dr. Devine has recreated a "decade of confidence" in organized social work as a background for the '30's which Henry Seidel Canby has christened a decade of fear. The book includes not only the problems that confronted social work and the methods for dealing with them but also the political and social setting which affected them. As Dr. Devine describes the various activities of the New York Charity Organization Society under his directorship he sees also the larger issues and underlying pressures in his experiences as they are related to present-day social work.

The program of the New York Charity Organization Society at the turn of the century was broad. An interest in individual families and the best ways of helping them led to the organization of the famous Tenement House Committee which assisted Governor Theodore Roosevelt in state and local housing reform. Of particular interest to public health nurses is Dr. Devine's account of the Committee on the Prevention of Tuberculosis among whose members were Dr. Hermann M. Biggs, Dr. S. A. Knopf, Dr. Edward L. Trudeau, and Lillian D. Wald. Its program included

research into the social aspects of tuberculosis, education of the public, and development of better treatment facilities. The New York School of Social Work and the *Survey* were also started as a result of the impetus of the agency's work.

When Social Work Was Young may be the history of one period in a single social agency but it is linked with nationally important reform and social work trends. Progress was along a broad front. Not only workers in social agencies, but doctors, lawyers, architects, bankers, writers, informed citizens, those connected with the labor movement, government, and education associated themselves with the work.

LEAH FEDER
St. Louis, Missouri

PARLIAMENTARY PROCEDURES

Three articles on "Parliamentary Procedures" were published in *The American Journal of Nursing* in September, October, and November 1939. The articles discuss such topics as duties of

officers, meetings, committees, voting, motions, and amendments. The material was prepared as a guide for inexperienced nurses who do not feel competent to conduct business meetings. Lists of questions which are answered in the articles are included.

LESSON OUTLINES ON MATERNAL CARE

The lesson outlines prepared by the Maternity Center Division of the Visiting Nurse Association of Brooklyn for use in teaching classes of prospective mothers have been completely revised. There are seven lessons which cover antepartum care, nutrition of the family and of the pregnant and nursing mother, clothes for the pregnant and nursing mother, the baby's clothes, the baby's supplies, the baby's bath, and the after-care of mother and baby. There is also a lesson outline on the preparation for delivery. A four-page bibliography is included. The set may be obtained from the Association at 138 South Oxford Street, Brooklyn, N.Y., for 45 cents.

RECENT PUBLICATIONS AND CURRENT PERIODICALS

MENTAL HYGIENE

PSYCHOLOGY AND THE NURSE. Frank J. O'Hara, Ph.D. W. B. Saunders Company, Philadelphia, 1939. 252 pp. \$1.75.

THE MENTAL HYGIENE MOVEMENT. Department of Philanthropic Information, Central Hanover Bank and Trust Company, New York, 1939. 72 pp.

A brief survey of the history, achievements, and needs of the mental hygiene movement.

A TEXTBOOK OF PSYCHOLOGY. Maude B. Muse. W. B. Saunders Company, Philadelphia, 1939. 484 pp. \$2.50.

NURSING MENTAL DISEASES. Harriet Bailey. The Macmillan Company, New York, fourth edition revised, 1939. 264 pp. \$2.50.

INDUSTRIAL NURSING

AN INDUSTRIAL DEPARTMENT OF HEALTH. Bulletin Number 9, Northwestern University Medical School, Department of Industrial Medicine, Chicago, 1939. 56 pp. \$2.

Summarizes opinions of many authors in a brief manual outlining adequate medical service for the sick and injured in industry.

THE HEAD AND EYE PROTECTION CODE OF THE NATIONAL BUREAU OF STANDARDS. M. G. Lloyd. *The Sight-Saving Review*, June 1939 p. 98.

Includes a brief discussion of types of hazards for which eye protection is needed and the proper fitting and sterilization of goggles.

UTAH EVALUATES INDUSTRIAL HYGIENE PROBLEM. Office of Public Health Education, United States Public Health Service. *The Health Officer*, January 1939, p. 236.

A survey "to determine the extent to which workers are exposed to disease-producing substances and materials in the course of their employment."

TUBERCULOSIS CONTROL IN INDUSTRY. W. A. Sawyer. *The American Review of Tuberculosis*, April 1939, p. 456.

Report of results of a program to control tuberculosis in a group of industrial workers.



• A full-tuition scholarship in health education is offered again this year to a public health nurse, by the Massachusetts Institute of Technology at Cambridge, Mass. This scholarship of \$600 covers the cost of tuition for the scholastic year, beginning in September 1940 and closing in June 1941.

The scholarship will be awarded to a candidate recommended by the National Organization for Public Health Nursing. The award will be based upon the nature and quality of the previous academic work of the applicant, the ability which she has already shown in professional work in the field of public health, her need for scholarship aid, and the probable value of her further contribution to health education. Consideration will be given only to those candidates who possess a bachelor's degree. Those possessing a degree may count their work at the Institute toward a Certificate in Public Health.

The scholarship will be awarded in June 1939 and applications should be received not later than May 1. All those who are interested in this scholarship may write to the National Organization for Public Health Nursing, 50 West 50 Street, New York, N.Y., for application blanks.

A similar scholarship is available to teachers through the National Tuberculosis Association, 50 West 50 Street, New York, N.Y.

• An institute on the handicapped child was held under the sponsorship of the Committee on the Care of the Child of the Illinois State League of Nursing Education in Chicago, Ill., on November

30. Of the 180 people registered, 77 were engaged in pediatric nursing and 20 in orthopedic nursing.

• The Public Health Placement Service of the Nursing Bureau of Manhattan and Bronx, New York, N.Y., was given official approval as a professional placement agency by the N.O.P.H.N. at the meeting of its Advisory Committee on Vocational Counseling on December 28. Letha Allen is the vocational secretary in charge of public health placements and the office is located at 205 East 42 Street, New York City.

• Graduates of the University of Pennsylvania school of nursing who attend the Biennial Convention in Philadelphia are invited to an alumnae tea at the nurses' home, 320 South 34 Street, from 4 to 6 p.m., Wednesday, May 15.

• Urgent requests for medical and health books are being received by the World Federation of Education Associations from teaching centers in the war areas. Nurses who would like to make contributions of books to organizations carrying on the training of nurses, doctors, and sanitarians in the face of tremendous odds, are invited to send a list of the titles of such books to Sally Lucas Jean, 200 Fifth Avenue, New York, N.Y. Miss Jean will then inform the sender where to mail the books.

• There were 135 nurses in attendance at the New Jersey State Health Education Meeting for School Nurses in Atlantic City, N.J., November 9 and 10,

1939. The physical and emotional health of the school child was the theme of the program. This was the eleventh annual meeting of school nurses as a section of the State Education Association meeting.

• The School Nursing Section of the American Association for Health, Physical Education, and Recreation—which is a division of the National Education Association—will meet at the Hotel Stevens in Chicago, Ill., April 24 to 26. At the main meeting at 2 p.m. on April 25 there will be a discussion of the status of the school nurse in this country, and the probable monies available from the United States Government for training school health personnel. The question of continuance of the section will also be discussed.

CORRECTION: Official Directory of Public Health Nurses, January 1940, page 67.

Federal Security Agency

Bureau of the U. S. Public Health Service,
Public Health Nursing Service

Senior Public Health Nursing Consultant,
Pearl McIver, U. S. Public Health Service, Washington, D.C.

Public Health Nursing Consultant, Helen Bean, U. S. Public Health Service, Washington, D.C. (On leave of absence.)
Public Health Nursing Consultant, Mary J. Dunn, U. S. Public Health Service, Washington, D.C.

Regional Public Health Nursing Consultants and Territory

Mary D. Forbes, Sub-Treasury Building, Wall, Pine, and Nassau Streets, New York, N.Y.—Maine, New Hampshire, Vermont, Massachusetts, Connecticut, Rhode Island, New York, New Jersey, Pennsylvania.

Olive M. Whitlock, 1413 Park Road, Northwest, Washington, D.C.—Delaware, Maryland, West Virginia, Virginia, North Carolina, South Carolina, Georgia, Florida, District of Columbia.

F. Ruth Kahl, Room 853, U. S. Court House, Chicago, Ill.—Ohio, Indiana, Illinois, Michigan, Wisconsin, Iowa, Minnesota, Nebraska, North Dakota, South Dakota.

Donna Pearce, 210 State Street, New Orleans, La.—Alabama, Mississippi, Louisiana, Tennessee, Kentucky, Missouri, Arkansas, Oklahoma, Kansas, Texas.

Anna Heisler, Room 112, Federal Office Building, San Francisco, Calif.—California, Oregon, Washington, Idaho, Nevada, Utah, Montana, Wyoming, Colorado, New Mexico, Arizona, Alaska, Hawaii.



PUBLIC HEALTH NURSING

Official Organ of the National Organization for Public Health Nursing, Inc.

Can Democracy Provide for Its Children?

THE APPLAUSE subsided and there was silence in the great East Room of the White House as the five hundred members of the Conference representing the children of America listened to the voice of the President of the United States accepting the findings of the Conference in a nationwide broadcast. The crystal chandeliers caught and reflected the lights, illuminating the rich red hangings, the mirrored fireplaces banked with flowers, the portraits of George and Martha Washington on the wall.

The President was speaking to the assembled group:

You tell us that more than half the children of America live in families that do not have enough money to provide fully adequate shelter, food, clothing, medical care, and educational opportunity.

More than in any previous decade, we know how to safeguard the health of parents and children. . . . It was one thing to let people sicken and die when we were helpless to protect them. It is now quite another thing to leave a large portion of our population without care.

This was a historic moment in the fourth of the White House Conferences called by presidents of the United States at the beginning of each decade since 1909 to study the needs of child life in America. Five hundred people from every state in the Union and every territory of the United States were assembled at the Nation's Capital on January 18-20. Representatives of agriculture and industry and labor, citizens and professional people—they came from widely different areas and back-

grounds, bringing to the discussions all shades of opinion on social and religious and political and economic questions. Here was democracy at work—democracy facing a challenge of its effectiveness to provide equal opportunity for the children of the nation.

The groundwork for the White House Conference on Children in a Democracy was laid last April when a planning committee of 70 members—on which the N.O.P.H.N. was represented by its president, Grace Ross—outlined the work to be done and the method of procedure to be followed.

During the intervening months a research staff working with committees and consultants drawn from the membership had prepared special reports in eleven fields bearing on child life—including health, education, religion, family life, child labor, housing, and various economic problems. A composite report covering all aspects of child life and containing highlights of the special reports was presented to the Conference for criticism or approval by Homer Folks, secretary of the New York State Charities Aid Association, who was chairman of the Report Committee.

"MAKING DEMOCRACY WORK"

The Conference was opened on January 18 by Frances Perkins, Secretary of Labor, who said that in the discussion and debate of many groups and points of view "lies the wisdom for making democracy work." She voiced the hope that out of the findings of the Conference we will know what ought to be done and what reasonably can be done

for children within the decade to follow.

During this first session, vital points in the reports were given special emphasis in short discussions by members of the planning and report committees. The necessity for raising wage levels and abolishing child labor as first steps in a program for child health and education was stressed by Elisabeth Christman, secretary-treasurer of the National Women's Trade Union League, who reviewed the appalling facts in the economic report. Miss Christman called attention to the findings that in 1935-36 over one million families had a yearly cash income below \$250, and half of the nation's twenty-nine million families had a yearly income of less than \$1200.

WHO ARE THE "MEDICALLY NEEDY"?

Existing inequalities in the distribution of medical care and the need for redefining the term "medically needy" were brought out by Dr. A. Graeme Mitchell, professor of pediatrics at the College of Medicine of the University of Cincinnati. Doctor Mitchell also called attention to the importance of having the contribution of all groups to meet the total needs of the child.

A housewife and mother, Mrs. Katharine Dummer Fisher, pled for the living of democracy in family life and expressed the belief that whatever changes may take place externally in society, the important things endure.

A program which lays new emphases on positive health with provision for adequate nutrition, recreation, and housing was urged by Dr. C.-E. A. Winslow. Doctor Winslow spoke in favor of the proposed national health program as one of real economy—which he defined as the wise spending of money in contrast to parsimony—looking toward the conservation of the health and welfare of the nation's children. He called attention to the fact that the proposed plan provides for local experimentation and initiative rather than contemplating a

single pattern for the entire country.

The group on Health and Medical Care for Children, headed by Dr. Henry F. Helmholz of Minnesota, was one of eleven which met during the Conference to discuss and revise the reports in special fields. Most of the twelve nurses at the Conference, including the four representatives of the National Organization for Public Health Nursing, attended this group meeting. The recommendations in the health report embrace a comprehensive program for maternal and child care, including the preparation of professional personnel and the stimulation of research. The appointment of a National Nutrition Committee by the President, to promote a national program for better nutrition of children, is suggested.

Gratifying recognition is given throughout this report to the nurse's contribution to the child health program. Again and again she appears in the picture—assisting in prenatal and delivery care of mothers, giving care to the newborn baby, participating in child health conferences and school health programs, supervising midwives, nursing the sick child, consulting with families on mental health. A statement giving a definite place to the nurse-midwife in the maternal health program of rural communities is also embodied in the report.

On Friday, January 19, the entire assembled Conference had its day with the general report, subjecting it to critical scrutiny, additions, subtractions, and modifications, and finally accepting it. The revised report will be published at a later date.

Highly controversial topics had obviously been filtered out in the preliminary discussions so that the major work of the Conference would be finished in the allotted time. However, one issue, the proposed federal child labor amendment, was brought up from the floor, and after lively discussion of the *pros*

and *cons* the Conference went on record as approving the passage of the amendment.

FACING THE FUNDAMENTAL ISSUE

Throughout its meetings the Conference realistically faced the inescapable fact of the fundamental economic problem, the "deep-rooted violations of democracy's commitment" to its children "due to the nationwide economic inequality" as one speaker had phrased it. "Provision of economic aid in the home is the first obligation of society toward children whose parents cannot give them the basic material essentials of life," is the opening sentence of the recommendations on economic aid to families. More than once during the two days the ominous words "zero hour of democracy" recurred in the discussions, recalling to all those present that democracy's ability to provide for the welfare of its children is on trial in the world today.

The White House meeting on Friday night was the high point of the Conference. The five hundred delegates were received by Mrs. Roosevelt, dressed in a cheerful red evening gown, her warm, friendly greeting for each delegate undimmed at the end of a fatiguing day. The crowd taxed the capacity of the great East Room and many stood during the entire evening. Some—including Nathan Straus, administrator of the United States Housing Authority!—even sat on the floor. Secretary Perkins presided and reiterated the purpose of the Conference—to "recommend a pattern of behavior which will draw the allegiance of the American people."

A kindly, gray-haired, motherly looking woman was introduced by Miss Perkins. She was Mrs. W. H. Ahart, president of the Associated Women of the American Farm Bureau Federation, who spoke on "The Significance of the Conference to Parents," pleading for a program which will provide hope of employment for the young people of today.

Mrs. Ahart told the group that when youth fears the future it becomes fertile soil for the seeds of discontent.

Homer Folks, who was present at the first White House Conference convened 30 years ago by President Theodore Roosevelt, reminded the group that none of the recommendations in the report are "self-starting" and that a follow-up program will be necessary to translate the findings into action. Miss Perkins then presented the report of the Conference to the President of the United States.

CHARTING THE COURSE AHEAD

And now the President was concluding his address to the Conference and to the nation:

You have charted a course for ten years or more ahead. Nevertheless, the steps we take today will determine how far we can go tomorrow and in what direction.

I believe with you that if anywhere in the country any child lacks opportunity for home life, health protection, education, or moral and spiritual development, the strength of the nation and its ability to cherish and advance the principles of democracy are thereby weakened.

The next morning the Conference settled down to the practical task of how to put the program into effect. A plan for applying the findings and recommendations was proposed in a nationwide broadcast by Mrs. Saidie Orr Dunbar, president of the General Federation of Women's Clubs, who was chairman of The Committee on the Follow-up Program. (Mrs. Dunbar is a member of the Board of Directors of the National Organization for Public Health Nursing.) A more effective machinery for working together seemed to be the paramount problem. The recommendations for the follow-up include specific plans for such machinery.

A nongovernmental National Citizens' Committee of 25 members is to be appointed to promote education of the

public, to work toward the coordination of national organizations, to cooperate with governmental agencies, and to assist with the development of state programs for carrying out the objectives of the conference. A federal inter-agency committee is to be organized to work toward coordinated planning on the part of federal agencies, cooperation with the National Citizens' Committee and with state inter-agency committees which may be formed, and cooperation between federal and state agencies. State

and local follow-up programs are also to be stimulated.

Thus the fourth White House Conference drew to a close with its work only just begun and with a profound feeling on the part of all those present that the future of democracy lies not in what is happening outside the bounds of our own country but in the success with which democracy is able to solve its own problems and provide a full and rich life for its children.

P. P.

THE SUBSIDIARY WORKER IN THE HOME

SINCE THE FIRST district nurse climbed the tenement stairs to visit a sick mother, the public health nurse has felt a responsibility for what happened to her patient during the twenty-three hours—or the two or three days—from one visit till the next. Who is to look after the patient's needs? Who will prepare the meals, clean the house, dress the children? If a sister or aunt is in the home, the nurse teaches her to give interim care to the patient; and she also serves as housekeeper. Or, less satisfactory, a kindly neighbor may offer to perform the most necessary tasks. If the husband is unfortunate enough to be unemployed, he is sometimes taught to bathe the baby, change the patient's bed, and play the housewife.

But every nurse has many families who have no relative or neighbor to carry on. The patient is given her bath and care. She is left comfortable and rested. Then what? The house is unswept. The stove grows cold. The children come home from school hungry. The patient lies fretting. Her bedclothes are disheveled. She needs simple nursing care, such as a sister or aunt could be taught to give.

What is the answer? A capable

woman who will be at once housekeeper and home nurse; who will cook and clean and look after the children and give care to the patient between visits of a graduate nurse. A woman who knows what to do, and equally important, what not to do; who won't pour patent medicines down the baby's throat when he cries; who knows that fried foods are not the best thing for children and that green vegetables are an inexpensive source of minerals and vitamins. A woman who can give a simple bed bath such as thousands of women have learned in Red Cross home hygiene classes; who can carry on the work that any intelligent mother knows how to do, but who cannot afford to do all this for nothing because she has to earn her living. In short, a practical nurse, a nurse attendant, a nursing aide, a subsidiary worker—or whatever she may be called.

For centuries women without professional training have nursed for hire. They will always be with us, because they meet a fundamental human need. In rural areas they are often the only persons available to care for the sick in the home. In urban areas they help to ease the burden of the household in

which there is a chronically ill or a convalescent patient; where there is mild illness which does not require a full-time graduate nurse; where the household is disrupted by the illness of the wife and mother.

What responsibility have we, then, for the protection of the public which employs these women? Shall we pretend, like an ostrich, that they do not exist? Or shall we take measures to assure their proper preparation for the tasks they assume; support legislation requiring their license to practice, so that the state can control their activities; utilize appropriate community facilities for their training and supervision?

This problem is a source of deep concern to the three national nursing organizations. Their Joint Board of Directors voted in 1936 that the nursing profession has a "responsibility" for the control of these workers, and appointed a Joint Committee to Outline Principles and Policies for the Control of Subsidiary Workers in the Care of the Sick. This committee outlined a list of home duties for subsidiary workers placed through nursing agencies, and made suggestions regarding the selection and supervision of such workers. (See *PUBLIC HEALTH NURSING*, July 1939, page 398.) In 1938, the Joint Board went on record as favoring the state licensing of all those who nurse for hire. In January 1940, a list of activities of ward helpers and orderlies in hospitals, prepared by the committee, was approved by the Joint Board.

A suggested outline of a course for the preparation of subsidiary workers under nursing agencies has been drawn up by the committee. This course, six to nine months in length, includes theory and classroom practice and supervised experience in home and hospital. It

specifies minimum qualifications for applicants, requirements for establishing a training program, and personnel necessary to carry on the course.

In several communities, public health nursing agencies have offered facilities for the supervision of these workers in the home. Two such projects, in Detroit, Michigan, and Brattleboro, Vermont, were described in this magazine in 1939. (April issue, page 223, and March issue, page 166.)*

The training and supervision of subsidiary workers are still in an experimental stage. Their preparation should be carefully planned so that the protection of the patient will be assured, and the standards of skilled, professional nursing, so carefully built up to safeguard the patient, will be maintained.

Two recommendations of the committee accepted by the Joint Board of Directors in January, are of interest. One, "that no formal courses for the preparation of subsidiary workers should be approved until such time as a method for the control of the practice of subsidiary workers be devised" intends to forestall the hazard of workers with a short course of training attempting to practice nursing which the state cannot control—as it can the practice of the graduate nurse. The other recommendation contemplates "a study of legislation to be enacted in states which wish to provide for the licensing and control of the practice of these workers."

Every public health nurse will want to be informed on the work of the committee which represents us all in the study of this vital problem.

P.P.

*See also "A Community Nursing Service," by Marion Wetzel and Beatrice Tremper, *The American Journal of Nursing*, January 1940, p. 40.

The Merit System

By ALBERT H. ARONSON

The underlying principles of the merit system are discussed by the chief of the State Technical Advisory Service of the Federal Social Security Board*

THE PUBLIC health nursing profession is, of course, interested in the improvement of the quality of the public service, in gaining public recognition of high professional standards, in offering opportunity to all qualified nurses to compete so that the best qualified may enter the service, in assuring security of tenure for those performing satisfactorily, and in providing opportunity for professional growth and promotion on the basis of performance.

The best way to obtain these objectives is through a merit system. No system is perfect; but by and large, no better means has been devised for improving the quality of public service in the long run than to establish, under reasonable rules, a system of selecting public personnel through open competition administered under nonpartisan auspices. The attainment of good standards is then not dependent on the continuance in office or the will or judgment of a single administrator. A sound merit system must be built upon the continuing active coöperation of administrative officials, the participation of professional groups, the utilization of practical personnel techniques, and the gaining of public understanding and support.

THE BEST SHOULD SERVE THE STATE

A merit system is often thought of in negative terms, as being concerned merely with the exclusion of political considerations from public employment. If it is to be effective it must be more than that. We could attain nonpartisanship in selection by less expensive means than examinations, such as by holding a lottery to give out jobs. Back of the examination is the idea that the best should serve the state.

The selection of the best is the central theme but other aspects of progressive personnel administration are essential to a merit system. There must be provision for sound and equitable job classification and compensation plans, effective and just supervision and rating of performance, dynamic staff development, promotion for the most capable, reasonable security for the satisfactory, separation of the incompetent and the faithless, and conditions of employment that recognize individual human dignity.

The examining process is an attempt to judge individual differences on an objective, reliable, and valid basis related to the particular job for which applicants are competing. It utilizes appropriate practical written tests, oral interviews and investigations, and ratings of training and experience. While early civil service examinations were sometimes of a purely academic character, being concerned with school subjects, the modern examination is designed to

*The opinions expressed in this article are those of the author and do not reflect the official views of the Social Security Board.

gauge the capacity of the applicant for a particular position and can be a useful instrument for measuring professional and technical skills and aptitudes.

WRITTEN EXAMINATIONS

In any professional field there is a body of professional knowledge which can be measured reasonably well by written examination. Such examinations must, however, be constructed by subject-matter specialists in the professional field, whose judgments command the respect of those in the field. In order for an examination to be reliable and valid, the use of certain recognized examining techniques is necessary. The collaboration of examining technicians—persons who have studied the field of tests and measurements—and subject-matter specialists is, therefore, essential to the construction of examinations worthy of respect. This fact has been sometimes overlooked in the construction of the examinations both for civil service jurisdictions and for professional certification.

MEASURING SOCIAL EFFECTIVENESS

The written examination does not measure the social effectiveness of the applicant. We know that success on the job may depend on coöperativeness, tact, ability to handle people, and other qualities which our written examinations do not test. Two devices may be employed with reasonable effectiveness to measure these qualities. First, an oral examination to appraise the personality of the applicant may be given by a board composed of persons who are impartial and whose judgments are valued. It is not necessary to discuss the dangers inherent in this process and the safeguards that have been evolved. It should be noted, however, that this part of the examining process has an important contribution to make in positions which involve public contacts or supervisory responsibility.

Another way of measuring the personal qualities of the individual is the appraisal of experience. This, coupled with a rating on education, may give a very valuable index of the abilities of the applicant. The establishment of minimum qualifications of training and experience for entrance to the examination is used to confine the more costly parts of the examining process to those who have a reasonable chance of success. The rating of training and experience as part of the examination should involve the use of professional consultants and should provide for appropriate credit on a qualitative as well as a quantitative basis. The verification of the applicants' records through personal investigation or confidential written inquiry constitutes part of this process.

In order for any examination to be successful, it is important that promising applicants be attracted to it. An examination can, of course, produce no better eligibles on the top of the list than the best candidates who take the examination. The recruitment for the public service of promising persons is a responsibility of those in the professional field as well as those directly connected with the examining process.

DEFINING JOBS

The development of a job classification plan is necessary prior to the administration of an examination program. This involves the analysis of the duties and responsibilities of the various jobs in an organization so that jobs may be clearly defined and administrative problems as to lines of authority and overlapping responsibility may be clarified. Job classification results in the establishment of classes of positions, each class consisting of jobs which are sufficiently alike to permit the use of the same title and the establishment of similar qualifications and a common range of pay. Job classification should

be understood to be a process not of establishing but of defining jobs which have been set up by appropriate administrative action. It is a process in which administrative officials, professional workers, and personnel technicians must collaborate.

When jobs have been arranged in orderly classes, a compensation plan based upon the principle of equal pay for equal work should be established. This would involve a determination of an equitable entrance salary and an equitable maximum for each class of work, and the establishment of appropriate intervening salary steps to provide for pay increments on the basis of increased value through long service and superior performance.

PROMOTIONS

A merit system should provide appropriate methods for the promotion of employees who have the capacity to do jobs of higher grade. Promotional systems may be either competitive or noncompetitive. Under a competitive promotional system, employees in lower classes take a competitive examination, and promotion is limited to those who are at the top of the promotional lists. Under a noncompetitive system, an individual is selected for promotion by the administrative official but must be certified as qualified on the basis of his training and experience, and if necessary given an appropriate examination for the higher grade of work.

In order to keep the service trim, it is necessary that there be a means of separation of persons who do not give satisfactory service. It is commonly thought that a merit system insures life tenure. This is not so and should not be so. A merit system should give job security to an individual who is doing satisfactory work, and to this end it should include the requirement that a regular employee be given a statement of charges and an opportunity to answer

them before any removal is made. A merit system should also include some type of appellate procedure. This may be a procedure in which an impartial body, after a hearing, takes action on the reinstatement or separation of the employee concerned, or it may merely provide for a recommendation by such an appellate body to the appointing authority. If there is protection against political and capricious removals, it is not believed that the supervisor should be unduly restricted in his authority to make removals for cause.

There should also be provision for just reduction in the force when there is curtailment of work or of funds. A formula for such layoffs should be developed under the merit system so that relative efficiency, seniority, dependents, and other relevant factors may be given due weight.

SERVICE RATING PLAN

In order to provide a record as to the service of employees, both for the protection of the employees and as a basis for administrative actions in promotions, separations, and transfers, some type of service rating plan under which supervisors periodically rate the performance of employees is regarded as an essential of a sound personnel program. No service rating plan has been devised which is wholly satisfactory, but where these plans are honestly administered the consensus is that they are a contribution toward good management. This is another area where there is need for professional participation.

A sound personnel system would also include provision for sick leave, vacation, and educational leave on a systematic rather than a whimsical basis.

The utilization of public jobs for political spoils has resulted in the practical necessity of excluding from active participation in political campaigns civil servants who are to have security of tenure despite changes in administra-

tion. This means that while such employees retain the right to vote and to express their opinions privately, as a condition of employment they relinquish the right to hold party office, solicit campaign funds, or engage in other activities which would cast doubt upon their impartial performance of their official duties.

If a merit system is to succeed it must offer opportunities for staff development. Employees must have an opportunity for self-expression in the job and for continuous growth. This implies the development of an adequate in-service training program which is attuned to the needs of the organization, which is based upon recognition of the education and abilities of persons in the program, which faces the special problems of adult education, and which takes cognizance of the differences between in-service courses and professional education.

MERIT SYSTEMS IN STATES

Merit systems to cover employees in the various programs under the Social Security Act are now being organized in those states which do not have statewide civil service laws, under standards recently promulgated by the Social Security Board and by the Children's Bureau. The United States Public Health Service has also indicated that it will require the development of merit plans. Rules and regulations for the operation of such systems are now being formulated. In the interests of economy and efficiency, joint merit systems are being established in many states to serve the several state departments administering programs under the various titles of the Social Security Act.

Where a merit system is set up other than as a statewide civil service system—that is, where such a system serves a single department or a few departments—it is recognized that obtaining public support and understanding is

a difficult problem. The best means of gaining recognition for an impartial system is the establishment of a merit system council or committee of high-minded citizens of standing in the community who serve on such a body as a civic duty. Examinations can best be administered under a single individual experienced in the examining field who at the same time has a knowledge of his own limitations and is ready to call upon professional groups for necessary assistance in the examining process.

Under the merit systems being established under the Social Security Act certain preferences may be given to incumbents of positions in the public service. The state agencies have the option of requiring the incumbents to take an open competitive examination and to be within reach for appointment from the top of the list, or merely to take the examinations on a qualifying basis, retaining their positions with a bare passing mark. Minimum qualifications of training and experience for entrance to the examinations may also be waived for incumbents. These preferences to incumbents have been attacked by some but are believed to be a reasonable middle course between requiring all persons, whether present job-holders or not, to compete without favor, and permitting the blanketing in of all present job-holders whether qualified or not qualified.

MERIT SYSTEM APPLIED TO NURSING

The responsibility of persons in the profession of public health nursing with respect to these merit systems may be treated under several heads: First, they should become acquainted with the basic principles and ideals of the merit system and offer support to these principles and ideals. Second, they should participate, where appropriate, in the discussions of the adoption of merit system rules and regulations, and in the appointment of merit system councils

composed of men and women of integrity and devotion to the improvement of the public service, and of merit system supervisors who are competent and high-minded. Third, they may assist in the development of appropriate examinations for public health nursing jobs through the cooperation of professional committees with merit system supervisors, through the utilization of the experience of state boards of examiners and of professional schools, and through intelligent and practical study and suggestion.

All this requires an open-minded approach to the grave problems of applying new personnel standards to an area where political pressures have too often dominated. The profession of public health nursing, which has developed professional standards and professional ethics, has a real contribution to make toward the improvement of personnel administration in the public service.

An article by Marion Sheahan on the application of the merit system to public health nursing will appear in the April issue.

PUBLICITY SPOTLIGHTS

Suggestions borrowed from commercial advertising were published in the September 1939 issue of *Channels*, the official organ of the New York Social Work Publicity Council:

Dramatize your story. Even the most commonplace product can present its story dramatically to attract attention and appeal to the emotions just as a headline in a direct mail letter should promote desire and win attention.

Self-participation pays. People like to take part. They appreciate behind-the-scenes privileges. They are flattered by an appeal to reason, couched in terms of their own self-interest.

Demonstrations popular. Showing how a product is made is always popular with the crowds. . . .

Success stories acceptable. People are impressed by the widespread use of a product; by research and prestige-building activities. . . .

Symbolism a poor salesman. Costly trimmings, beautiful arabesques, clever and original symbolic designs, when observed at all, attract more attention to the novelty of the display or the originality of the designer than to the product itself. Realism is far more acceptable. . . .

—*The Reporter*, New York, N. Y., June 1939

Many annual reports received by the National Organization for Public Health Nursing do not give the state in which the agency is located and the year of the report. These data may not seem necessary for the local community. However, local reports often travel far and wide, and identifying information is important for out-of-state people who may read them.



The airline stewardess must understand human behavior and use sound judgment in meeting unexpected situations

Nursing in the Skies

By MAXINE SCHRAM KEEFE, R.N.

IN ORDER to maintain and improve their high standards of service, American Airlines—in common with several other of America's major airlines—employs a select group of young women stewardesses, whose duty is to assist in providing passengers with every comfort and convenience of air travel. Attractive, capable stewardesses do not just happen. Their appointment indicates that they have qualified physically and mentally and have shown unusual aptitude for leadership. The qualifications are exacting, necessitated by the stewardess' potential value to airline passenger service—since her contacts with passengers are the ones most likely to be favorably or unfavorably recalled.

An applicant for a stewardess position must be a graduate, registered nurse in good standing. The necessity

for this basic qualification is often questioned. The company's requirements state that: "Registered nurses are employed because of their medical training and experience, education, self-discipline, personal attributes, devotion to duty, and experience in meeting and dealing with people."*

Applicants must be between 21 and 26 years of age. Length of service depends on the retention of required qualifications. A short career? Comparatively speaking, yes, but one filled with fascinating and educational experiences. To meet the varying service demands, applicants must be not more than five feet, five inches tall and weigh no more than 120 pounds, the weight being in good proportion to the height. Applicants

*American Airlines, Inc. Stewardesses (Qualifications, Duties of). (Mimeographed) Chicago, Illinois. Undated.

must be unmarried. A thorough physical examination is required every six months.

In addition, applicants must possess personal charm, poise, and refinement. Other important considerations are the ability to wear clothes well, correct speech, and enthusiasm for employment.

PREPARATION FOR THE JOB

A well planned training school is maintained, providing a six-weeks' comprehensive course of instruction. In a classroom which is delightful in its informality, young women representing many states of the Union, gather to obtain a knowledge of subjects far removed from the field of nursing education. Here they study meteorology, airway traffic control, primary aeronautics, radio, ticketing, company organization, and food service. Interspersed with

classroom activities are periodic observation flights on regular trips so that the student may have a background for practical application of material learned in training.

During this period of instruction, the student learns to appreciate the definition of an ideal stewardess as "a clean-cut, clear-thinking woman, adept in dealing with people, not too retiring and not too forward. She must have unusual powers of observation, sincerity, and understanding of people." The stewardess is expected to be able to answer passengers' inquiries on services of all airliners. To this end she studies flight routes, time tables, and itinerary planning.

The manual of instruction is the "state board" back of the stewardess. From this she learns her duties before, during, and after a flight. Personnel



Riding in the clouds,
the youngest passenger
feels secure in the
arms of this compe-
tent nurse of the skies



Lunch time in an airliner is a great adventure

regulations are outlined and include uniform regulations and advice for a well-groomed personal appearance. No effort is spared in the teaching of principles of service. The stewardess accepts a great responsibility for each of her passengers in flight. She must be prepared to give correct and complete information regarding flight conditions, and must be well informed on all points of interest en route. She is taught the requisites of a good conversationalist. She learns how to aid the first rider, and how to take the responsibility for children.

The stewardess who meets these requirements successfully indeed exemplifies the typical American girl. The opportunities open to her are varied and interesting. She gains much in experience. She has the opportunity to travel, to meet people, and to be a part of the progress of aviation.

The working hours of the stewardess

are irregular. Because of changing weather conditions, scheduled flights are subject to cancellation or are postponed in case of unfavorable flying conditions. Publicity engagements, special flights, and relief duty demand much of the stewardess' time. She is expected to be reasonably available for duty at all times.

The scheduled flying hours do not exceed 110 a month, with a maximum working day of ten hours. During a seven-day period, one 24-hour rest period is given. On short trips, such as from New York to Boston, the stewardess makes one or two round trips daily. The larger scheduled flights, such as from Chicago to New York, take one day, and the stewardess makes the return trip the following day.

The public health implications of stewardess work lie mainly in the underlying qualifications which are necessary for both types of work—an interest in

people, an understanding of human behavior, and the ability to adjust to changing situations. A thorough understanding of mental hygiene is of importance both to the stewardess and to the public health nurse. Both types of work demand a keen awareness of situations and the versatility to meet and cope with any unexpected situation. Intrinsically, these two types of nursing have certain characteristics in common: both are exacting in their requirements and in return must be served with intense loyalty.

Undoubtedly there are fewer public health nurses engaged in stewardess work than nurses from other fields of nursing. In every field of endeavor there are individuals most suited for a particular type of work, and those who have advanced in the field of public health have attained the maximum of satisfaction in nursing by teaching pro-

motion of health and prevention of illness.

Public health experience is valued by air lines as preliminary training for a stewardess. This specialized education and experience are valuable in the stewardess' contacts with the public.

Trends in aviation progress indicate that aerial nurses will serve an important part in national defense programs and in future air duty. To this end, the only women's service organization in aviation, the Aerial Nurse Corps of America, is training women for nursing service under special conditions of flying. With the increasing use of aviation in national emergencies, in disasters, and in transportation of the sick, there will undoubtedly be open to nurses a new field of endeavor in service requiring of the nurse a combination of the qualifications of public health nurse and stewardess.

Use of Urea in Care of Cancer Patients

By WALTER L. MATTICK, M.D.

Urea is a safe and inexpensive deodorant and healing substance which is practical for use in the care of cancer patients in the home

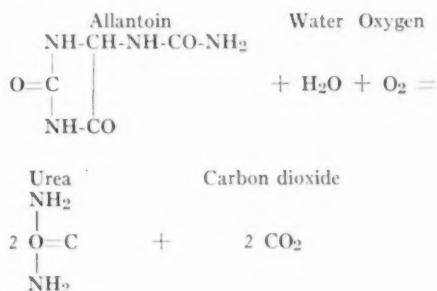
THE PROBLEM of the use of a safe, deodorant, and soothing dressing for ulcerations such as those found in cancer often arises, especially in the home. For years surgeons have been in the habit of excising such ulcers, especially of the breast, to the decided relief of patients and relatives. But in many cases such ulcers recur and the palliation is only temporary.

It is in the home treatment of these patients that the need for a safe, relatively nontoxic, and efficient agent which

can be put into the hands of average patient or lay attendant often arises. For such a purpose, the writer has for several years prescribed commercial preparations of crystalline urea. This substance is a constituent of the urine of animals and man and was the first organic chemical to be synthesized outside of the body from ammonium cyanate by Wöhler in 1828,¹ thus marking the beginning of the present era of organic chemistry.

The therapeutic history of this substance dates back to antiquity, to the use by primitive peoples of urine for wound dressings. From these early beginnings and its seemingly crude use we

have by slow steps advanced to the maggot treatment of suppurative wounds as developed during and after the World War. Curiously enough, the rationale of this maggot treatment was found to depend on a substance, allantoin, which when hydrolized in the presence of oxygen or air, yields urea, *i. e.*:



Since 1915 quite an extensive literature has developed around the therapeutic uses of this substance, particularly in the treatment of wound infections, chronic purulent otitis media, and cancer. Practically all of the early contributors stress the following actions and advantages: Urea is deodorizing, bactericidal, proteolytic, inexpensive, non-staining, relatively nontoxic, and relatively nonirritating. It retards granulations and promotes epithelization.

Regarding these actions and advantages, the following may be said. Practically all writers have called attention to its use as a satisfactory deodorant. Holder and MacKay have stressed the bactericidal action of strong solutions and also the solvent action on proteins which hastens the removal of incrustations, dead tissue, and debris—all of which by their mechanical actions and the harboring of bacteria are the chief deterrents of normal healing.² Pejuk and Ragat found urea effective in even weak solutions especially against the bac. diarrhoea, psittacosis, pyocyaneus, dysenteriae, enteritidis, and other organisms producing foul odors.³ Their observations were in most part confirmed

by Fougler and Foshay, who also found it of value against many strains of streptococci.⁴

The writer has used this substance during the past three years quite extensively in the treatment of cancerous ulcerations, other chronic purulent infections, and chronic purulent otitis media, with very satisfying results, and has found it both safe and efficient in the hands of the average patient.

The most useful methods of application are (1) as a powder (2) in solution commencing with the weaker and advancing to the stronger as required (3) in paste form.

The powder, which is very hygroscopic, may be dusted on smaller sloughs of the skin or blown into the external ear in chronic running ears, by the physician.

The solution in weak dilutions is most readily prepared by the addition of a teaspoonful of the commercial crystals to the ordinary eight-ounce glass of boiling water. This when cooled makes approximately a 2 percent sterile solution of this substance, or approximately the strength found in the urine. As these crystals are very soluble in water (100 gms. to 100 cc. water), saturated solutions are readily prepared. The solutions are preferably applied as wet dressings and renewed three or four times daily, or, in the treatment of chronic running ears, as a saturated solution dropped into the ear canal twice daily.

Pastes are preferred to ointments as urea is not soluble in oily bases. Although the use of lanolin or aquaphor may somewhat obviate this difficulty, the writer prefers the following prescription:

R_x		
Tragacanth (powdered)		10.
Alcohol qs		
Urea crystals (commercial)		20.
Glycerine		10.
Water, q.s.a.d.		100.
Sig: Apply twice daily as directed.		

In conclusion, the writer has been most satisfactorily impressed with the claims set forth for the therapeutic uses of this substance as herein described and has seen no untoward results from its

use. He can heartily endorse it for home use but believes that like all medicinal substances, its use should be supervised by a physician or a competent graduate nurse.

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STUDY OF COMMITTEE ON LAY PARTICIPATION

AN INTERESTING study having significance for the health field has recently been made by the committee on lay participation in social work of the Cleveland Chapter of the American Association of Social Workers. The study—made over a three-year period—covers the relationship of the layman in the operation of a social agency, his responsibilities, and his limitations. The committee's report following the study contains some interesting comments and suggestions that should be of help to public health nurses in developing volunteer service in the health field.

The importance of including lay participation in professional training courses is emphasized by this group: "From its conception the committee believed that there was a need for inclusion in the school curriculum of knowledge regarding the philosophy of lay and professional participation in social welfare. It seemed to the committee that such philosophy was basic to all fields of social work and should be presented as a part of an orientation course in the

beginning of the student training period." It was suggested that this material might be incorporated into a one-hour course.

Four policies evolved regarding the use of volunteers by this city are as follows:

1. The volunteer is a person who gives service to an agency without financial reimbursement and is valuable in supplementing the work of the professional worker by the service given, by bringing a breadth and variety of experience and viewpoints, and by interpreting the functions of the agency . . . to the community.

2. It is the responsibility of the agency to acquaint the volunteer with the total program of the agency and its relationship to the entire community setup. . .

3. It seems advisable to have a well equipped professional person responsible for all volunteers within one agency.

4. It was felt that the tasks assigned to volunteers should be clearly defined and essential both from the professional and lay point of view.

Complications of Diabetes

BY ALEXANDER MARBLE, M.D.

The public health nurse should have an understanding of the prevention and treatment of the complications which may occur in patients with diabetes mellitus

SINCE DIABETES asserts itself in such large measure through its complications, the prevention and treatment of these are of outstanding importance. In any hospital or clinic where large groups of patients with diabetes are assembled, it is often true that the majority have come for the relief of complications. Furthermore, success in the care of any diabetic patient over years of time consists largely in the avoidance of complications or in their prompt recognition and energetic treatment.

Individuals with diabetes are liable to any of the diseases which affect mankind in general. Thus a diabetic person may have heart disease, cancer, acute communicable diseases, and other conditions just as may any person in the community. In the present discussion, however, we are concerned with those conditions directly related to diabetes. The most important of these are: (1) diabetic coma (2) hypoglycemia due to insulin (insulin reaction) (3) arteriosclerosis, including gangrene of the extremities, coronary occlusion, cerebral hemorrhage, and nephrosclerosis (4) infections, particularly of the skin and urinary tract, including pulmonary tuberculosis.

DIABETIC COMA

Diabetic coma, or extreme diabetic acidosis, is a serious condition which represents the end-stage of uncontrolled diabetes. In our own clinic from 1898 to 1914, diabetic coma accounted for 63.7 percent of all deaths among diabetic

patients! Improved treatment by fasting reduced this percentage in the period from 1914 to 1922 to 41.6 percent. In the insulin era only about 6 percent of diabetic deaths have been in coma. This figure is still too great, but the remarkable change brought about by insulin is evident.

The onset of diabetic coma usually takes place over a period of hours or even days. The symptoms are notoriously vague, but consist at first usually of increased thirst, the passing of large quantities of urine, weakness, and headache, leading up to nausea, vomiting, and abdominal pain. Associated with the gastro-intestinal symptoms is a peculiar type of respiration characterized by deep, rapid, labored breathing. Drowsiness comes on, deepens, and finally passes into unconsciousness. The progress of symptoms can be stopped at any stage by the institution of proper treatment.

When one sees a patient in well marked diabetic coma, one finds an individual who is unconscious or nearly so and who is greatly dehydrated as shown by extreme dryness of the skin, the tongue, and the mucous membranes of the mouth, and by softness of the eyeballs. The mucous membranes of the mouth are often dull red and there may be marked inflammation of the gums. The pulse is rapid and weak and the blood pressure often is low. The abdomen may be held rigidly; distension of the stomach with fluid and of the bowel with gas may be present. The breath

often has a fruity odor. The muscles are flaccid and the reflexes often absent.

Examination of the urine shows the presence of large quantities of sugar and of diacetic acid and acetone. The blood sugar is high and the carbon dioxide combining power (or content) of the blood plasma is greatly decreased, indicating acidosis.

Treatment and prevention

Treatment consists in the prompt administration of adequate—and often large—amounts of insulin and of physiologic solution of sodium chloride. The initial dose of insulin may vary from 20 to 100 units and it may be necessary to repeat this dose two, three, four or more times at intervals of 30 to 60 minutes, depending upon the case at hand. The salt solution may be given either subcutaneously or intravenously, and the amounts so supplied plus that given orally should, in the average patient, total four or five liters in the first twenty-four hours of treatment. Almost without exception the stomach should be lavaged to relieve distension and to prepare the way for the giving of fluids by mouth. In certain patients, supportive medication, as with caffeine, ephedrin, epinephrin, or transfusion of whole blood, may be necessary.

The above treatment should be carried out under the constant supervision of a competent physician, and if at all possible, in a hospital where laboratory facilities are available day and night. Every patient with diabetic coma should be treated as an emergency; just as much insistence should be made on hospital treatment as in the case of acute appendicitis or other acute surgical conditions. It cannot be overemphasized that success in treatment depends upon constant personal attention by the nurse and physician accompanied by frequent tests of the blood and urine to gauge the effect of therapy.

The prevention of diabetic coma lies

in the constant supervision of all diabetic patients to be sure that the condition is kept under control. Diabetic coma usually arises, particularly in children, because of neglect in treatment—either by breaking of diet or omission of insulin or both. Diabetic coma may be precipitated also by acute infections, a fact which patients soon must learn so as to protect themselves. Since it is sometimes difficult to be sure about the diagnosis of coma, it is wise to teach patients to follow rules such as those outlined below:

If you feel sick:

1. Go to bed.
2. Have the urine tested for sugar.
3. Get someone to take care of you.
4. Call a doctor.
5. Take a hot drink hourly.
6. Take an enema.
7. On your doctor's advice, take regular or crystalline insulin at frequent intervals as long as the urine contains sugar.

INSULIN REACTIONS

Hypoglycemic reactions due to insulin, although not a serious complication, deserve careful consideration. Patients should not have frequent reactions. Not only may such attacks be embarrassing, inconvenient, and even dangerous at times, but their frequent occurrence in severe form may make it difficult for the patient and for other diabetics to secure and hold positions of responsibility.

The prevention of reactions is almost always possible and consists of proper regulation of the insulin dosage and distribution of food during the day. Patients soon learn that prior to strenuous or unusual exercise extra food must be taken for prophylaxis. The proper use of slowly-acting protamine zinc insulin has done much to lessen the incidence of reactions.

This complication has already been discussed by Dr. Howard F. Root in the preceding article in this series, "Treatment of Diabetes by Diet and Insulin," in the February 1940 issue.

ARTERIOSCLEROSIS

For reasons as yet not entirely understood, the diabetic person is prone to the development of arteriosclerosis prematurely. Much can be done to hold this tendency in abeyance by continuous and careful control of the diabetes over years of time. There is no doubt that hardening of the arteries is much more common in those patients whose diabetic condition has been poorly controlled. Whether the amount of fat in the diet has anything to do with the origin of early arteriosclerosis may be debated, but there is fairly general agreement that patients do better on diets higher in carbohydrate and lower in fat.

Arteriosclerosis affects diabetics chiefly in the older age-groups and there particularly by involvement of the arteries leading to the feet and legs, producing impairment of circulation and in some instances gangrene, and those supplying the heart muscle, producing coronary occlusion. Less common and not as distinctive of diabetes are lesions in the cerebral vessels with production of cerebral hemorrhage and thrombosis and those in vessels to the kidneys producing chronic nephritis.

To prevent arteriosclerosis generally one can, at the present time, do no better than to insist on excellent control of the diabetic condition. It probably is of value to strive to maintain a normal cholesterol content of the blood. In occasional patients this may remain high despite control of the diabetic condition and in these, reduction to normal may at times be accomplished by adjustment in the amount and type of fat in the diet. In considering arteriosclerosis in its specific manifestations, one is concerned chiefly with the protection of a given part of the body, recognizing limitations imposed by poor circulation. In this discussion the two most important complications of impaired circulation will be considered—peripheral gangrene and coronary occlusion.

Peripheral gangrene

Not uncommonly middle-aged or elderly diabetic patients find that as time goes on they develop aching or pain in the feet or calves on walking. This may gradually progress so that the discomfort comes on after less and less activity. The pain is relieved by rest, although in certain patients it may finally be present despite complete rest. Examination of the feet may show them to be cool or cold to the touch and careful palpation may fail to reveal any pulsation in the peripheral arteries. The skin over the feet may be shiny and atrophic. The treatment of this complication, due obviously to impaired circulation, consists in limiting activity to that amount which can be carried out comfortably and in attempting to develop collateral circulation in the feet by means of gentle exercises, as provided by graded walking and the Buerger board. There is some indication that the circulation may be improved slightly by mechanical means such as the use of a machine producing intermittent venous occlusion.

Not all patients with impaired circulation in the feet have pain as described above. Whether there has been pain or not, if on physical examination no pulsation can be felt in the dorsalis pedis or posterior tibial arteries, one may regard the feet as vulnerable. If a crack in the skin or ulceration with subsequent infection appears, the wound may not heal and the infection may not be overcome. Following slight injury, gangrene may develop and extend despite treatment. All too often the only successful treatment consists in amputation through the lower thigh of the affected leg because local operations and less radical amputations will be unsuccessful due to failure to heal.

Obviously prevention is worth far more than any means of treatment now available. Consequently, diabetic patients at their first visit should commence

their education in the matter of care of the feet. Rules such as the following should be taught.

Care of the Feet*

Hygiene of the feet

1. Wash the feet daily with soap and luke-warm water. Dry thoroughly, especially between the toes, using pressure rather than vigorous rubbing.

2. When thoroughly dry, rub with lanolin to keep the skin soft and free from scales and dryness. If the feet become too soft, use lanolin less often and rub once a day with alcohol.

3. If the nails are brittle and dry, soften by soaking in warm water, apply lanolin generously under and about them, and bandage loosely. Clean the nails with an orange-wood stick. Cut the nails only in a good light and after a bath, when the feet are very clean. To avoid injury to the toes, cut the nails straight across and do not cut them too short. If you go to a chiropodist, tell him you have diabetes.

4. If you have overlapping toes or toes that are close together, separate them by lamb's wool. If you have large joints or cramped-up toes, wear shoes that do not have box toes.

5. If over 60 years of age, take daily rest periods and remove your shoes at such times. Once a week ask someone to examine your feet.

6. Do not wear bedroom slippers when you should wear shoes. Slippers do not give proper support. Do not step on the floor with bare feet.

7. Wear shoes of soft leather which fit and are not too tight (neither narrow nor short). Wear new shoes one-half hour only on the first day, increasing one hour daily.

8. Use bed socks instead of hot-water bottles, bags, bricks, or electric heaters.

9. After 50 years one may hear and see less well, and the sense of feeling may be diminished. Remember this and be cautious about the feet.

Treatment of corns and calluses

1. Wear shoes which fit and cause no pressure.

2. Soak the foot in warm—not hot—soapy water. Rub off with gauze or file off dead skin in or about a callus or corn. Do not tear it off. Do not cut corns and calluses or try to remove them with patent medicines or other drugs.

3. Prevent calluses under the ball of the foot: By exercises such as curling and stretching the toes 20 times a day. By finishing each step on the toes and not on the ball of the foot.

Aids in treatment of imperfect circulation and cold feet

1. Exercises: Bend the foot down and up as far as it will go six times. Describe a circle to the left with the foot six times and then to the right. Carry out such exercises morning, noon, and night.

2. Massage the feet with lanolin or cocoa butter.

3. Do not wear circular garters or sit with the knees crossed.

4. If you have had or have been threatened with gangrene, keep off your feet five or more minutes each hour of the day, and if you have had an amputation of part of a leg, fifteen or more minutes each hour of the day.

Treatment of abrasions of the skin

1. Proper first-aid treatment is of the utmost importance even in apparently minor injuries. Consult your physician immediately.

2. Avoid strong, irritating antiseptics, such as sulphonaphthol and tincture of iodine.

3. At once after an injury, apply sterile gauze saturated with medicated alcohol or other mild antiseptic. Keep wet for not more than 30 minutes by adding more of the antiseptic solution. Sterile gauze in sealed packets may be purchased at drug stores.

4. Elevate the foot, and as much as possible until recovery, avoid using it.

5. Consult your doctor for pain, redness, swelling, or any other signs of inflammation.

Coronary occlusion

In the last two or three decades there has been a startling increase in the incidence of coronary occlusion among individuals in the general population. Great as has become the frequency of this form of heart disease among people in general, it has been exceeded by the frequency among diabetic patients in corresponding age-groups. The known means of prevention are not great at the present time although it has been suggested that high-tension living predisposes to angina pectoris and coronary disease, and that freedom from worry and nervous strain helps prevent these conditions. Excellent control of the diabetic condition should be insisted upon as a possible preventative, and patients exhibiting symptoms

*Adapted, with permission, from *Diabetic Manual*, by Elliott P. Joslin, Lea and Febiger, Philadelphia, sixth edition revised, 1937.

of angina should limit their activity in order to keep within the bounds of comfort. Drugs which increase the blood supply, such as theobromine, are often of help, particularly if combined with small doses of a sedative such as phenobarbital.

INFECTIONS

Persons with diabetes notoriously have a lowered resistance to infection. It is true, however, that insofar as the diabetic condition is kept under good control the ability to overcome infections approaches the normal. In patients in whom the disease is not under control, particularly over long periods of time, the resistance to infection is apt to be impaired. Infections of the skin and urinary tract are most characteristic. In addition, pulmonary tuberculosis seems definitely more common than in persons of similar age in the general population.

Infections of the skin

Infections of the skin take the form of furuncles, boils, or carbuncles. Also to be considered are the infections which develop in the extremities, particularly in the feet; these present a great problem in elderly patients since often, because of impaired circulation, they spread rather than heal. In preventing infections of the skin the diabetic must learn early the importance of cleanliness. The diabetic should be the cleanest person in the community. Minor infections and breaks in the skin must be treated with great respect to avoid increase in size and extension. In the presence of a fully developed boil or carbuncle, great care must be used to prevent the formation of satellite infections in the surrounding healthy tissue.

A carbuncle is one of the most serious complications of diabetes. It is more common in men than in women and occurs most frequently over the back of the neck or between the scapulæ. Treatment consists in the application of heat and at times x-ray until localization has

taken place. Drainage is then carried out by means of a wide crucial incision. The postoperative care of a carbuncle usually consumes several weeks of time.

Urinary tract

Infections of the urinary tract are distressingly common among diabetic patients. In an analysis of 196 patients examined after death, Sharkey and Root¹ found that in 35, or 18 percent, there was evidence of purulent infection of the urinary tract. So impressed have we become with the danger of infection in the diabetic patient that we consider carefully before catheterizing unless forced to do so, because even under the good conditions prevailing in well regulated hospitals, infection may take place. In the treatment of urinary tract infections, fortunately there are now available new drugs, among which are mandelic acid, sulfanilamide, and sulfapyridine. These preparations, although highly beneficial in selected cases, may be dangerous if used indiscriminately and should not be employed unless the patient can be under constant supervision of a physician who has had experience in their use.

Tuberculosis

Some years ago Root² reported that pulmonary tuberculosis was more than ten times as common among diabetic children as among school children in Massachusetts of the same age. Furthermore, among patients who had recovered from diabetic coma and who were studied for a period of five years after an attack of coma, the incidence of pulmonary tuberculosis was 18 percent. Pulmonary tuberculosis ranks high as a cause of death among patients who, having withstood one or more attacks of diabetic coma, have died months or years later; among 52 such deaths, 15 were due to tuberculosis. Therefore it seems that uncontrolled diabetes prepares the soil for the growth of tubercle bacilli. Recent studies among our group of patients, however, give hope that tuberculosis is

becoming less common among diabetics.

In prevention it is important that patients keep the diabetic condition constantly under good control so as to maintain a high level of general health and resistance to infection. In order to institute treatment early, and therefore most effectively, it is highly desirable that x-ray pictures of the chest be taken at regular intervals among diabetic patients, particularly those who for one reason or another have failed to keep the disease under control. When the infection is discovered reasonably early and proper treatment is applied, good results may be expected in the diabetic with tuberculosis. Advanced disease, as represented by cavity formation, is of especially serious significance in a juvenile patient; rarely, if ever, is the outcome favorable.

OTHER COMPLICATIONS

Diabetic neuropathy

In any large group of patients with diabetes there will be many who complain of pains and aches variously over the body. Some of these patients will have pains for reasons unrelated to diabetes, as for example from chronic arthritis. In others, the pains will be more directly related to diabetes, being due to impaired circulation in the lower extremities. In others, pains down the legs will disappear after a severe diabetic condition has been brought under control by means of a restricted diet and insulin. In still others, however, the pain may persist for weeks or months even though the diabetic condition be brought under good control. When affecting the legs, the signs and symptoms are those of a peripheral neuritis with marked pain going down the legs, marked sensitiveness of the skin of the feet and legs to even light pressure, weakness and wasting of muscles, and diminished tendon reflexes. In some patients these persistent pains may affect the back or arms; in others apparently the nerves to the bladder, producing paresis or paralysis of that organ. Among

laboratory findings may be mentioned the fact that characteristically the total protein of the spinal fluid is increased without the appearance of white blood cells. Since the condition is apparently a generalized one it seems desirable to regard it as a neuropathy rather than a neuritis.

As in most other complications, the chief point in prophylaxis is excellent and continued control of the diabetic condition. Treatment consists in bringing the diabetes under control and keeping it so for weeks and months. During this period, rest, at times heat, analgesics, sedatives, and other types of supportive therapy are of value. There has been much discussion as to whether the neuropathies seen in diabetic patients are related to vitamin B₁ deficiency. Whatever the truth may be in this regard, it is certain that the giving of enormous doses of thiamin orally or parenterally almost never produces relief in anything like a dramatic or specific fashion. However, one does well to furnish an abundance of vitamin B₁; probably concentrated brewers' yeast is the best preparation to use. The diet should be planned so as to furnish an abundance of the known vitamins.

Disorders of the eyes

One of the most distressing complications seen in middle-aged or elderly diabetic patients is impaired vision. This is due most commonly either to cataracts or to vascular damage in the retina. Some years ago Waite and Beetham³ made an extensive study of the eyes of patients in our group, comparing the findings with those of non-diabetic individuals. They found that in incidence and type, the cataracts seen in diabetic patients did not differ from that seen in persons without diabetes. However, they did find a greatly increased incidence of deep retinal hemorrhages. The formation of hemorrhages and exudate may in an appreciable number of patients be of such serious grade

as to markedly impair vision and produce near or total blindness. The cause of these abnormalities in the eyes is not clear, although some have suggested that it might be long-continued mild sub-clinical acidosis, whereas others believe it rests upon a deficiency of vitamins B₁ and C. Our only means of prevention lies in insisting on excellent control of the diabetic condition and the supplying of a diet adequate in every respect.

COMMENT

Repeatedly in the above discussion it has been stated that prevention of this or that complication lies in adequate control of the diabetic condition. Such control must be continuous and extend over the lifetime of the patient. Diabetes is not an acute condition; in the present state of knowledge it is not curable. Treatment must be planned not for a day or a week, but for years of time. With this in mind, thorough yet simple instruction of the patient and his family regarding diabetes and its complications is all-important. It has been said that, other things being equal, the patient who knows the most lives the longest.

The public health nurse because of her close contact with the patient in his home and in the clinic has a unique opportunity to be of service. She may well be the first to suspect, from signs and symptoms, a hitherto unrecognized diabetic condition. She may be instrumental in arranging that proper treat-

ment with diet, and insulin if necessary, is begun. More than this, she can, by continued personal contact and encouragement, make sure that laxity in treatment does not creep in as time goes on. By her knowledge of the home conditions of a patient she may often be able to modify routine measures to fit the individual situation and yet maintain a high level of treatment. By instruction of patients in the care of the body, particularly the skin and the feet, she may prevent distressing complications. Once complications have arisen, she may recognize them at any early stage so that prompt treatment may be instituted. The reward for such efforts on the part of the nurse is great. With continuous control of their condition patients can live useful, happy lives—essentially as normal as would be possible without diabetes.

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This is the third of a series of articles on diabetes by the physicians of the George F. Baker Clinic, Boston, Massachusetts. The next article will appear in an early issue.



Osteo-Arthritis

By CARL RICHARD WISE, M.D.

There is no specific treatment for osteo-arthritis—a disease of the later years—but there are certain therapeutic measures which will make the patient more comfortable

OF THE two great causes of chronic joint disability; rheumatoid arthritis and osteo-arthritis, the latter is by far the more prevalent. It has been estimated that almost every person past 50 years of age can be shown to have joint changes due to the disease but that only about five percent have symptoms from it. On this basis there are well over one million people in the United States who are suffering in some degree from the disease.

Osteo-arthritis is generally considered to be a degenerative disease coming on in the later years of life, in direct contrast to the inflammatory forms, such as rheumatoid arthritis, which tend to occur in earlier age-groups and are either directly or indirectly connected with bacterial infection. It is often associated with other signs of advancing age such as arteriosclerosis, obesity, grey and falling hair, and general slowing down of activity. It is also known as hypertrophic arthritis and degenerative arthritis.

Joint changes are most frequently seen in the terminal finger joints, the knees, the hips, and the spine. The actual process begins as a roughening of the cartilage of the joint surface, at the edges of which there is lipping and spur formation. These irregularities consist of spongy bone covered with cartilage which is eventually completely worn off as dense bone is laid down. The joint changes are reflected in various symptoms in the patient. Early, there may be only stiffness which gradually be-

comes more uncomfortable. Later, continued pain may be present which is, of course, accentuated by exertion and motion of any kind. The stiffness and pain are often worse during damp and cold weather. The joints are rarely swollen although the knees occasionally contain an abnormal amount of fluid. They are not usually hot nor red and never become completely immobile. Often there is distinct creaking of the joint on motion; in fact, this is sometimes the only symptom which calls the patient's attention to the disease.

FORMS OF THE DISEASE

Although these changes are usually present in several joints, certain forms of the disease are so often observed that they have been given separate names.

1. Heberden's nodes. Most people past fifty develop thickening of the terminal joints of the fingers. A great many of these swellings never give any trouble, but often at the onset they are quite painful and stiff and many patients are more alarmed than sick with them. True, in some instances a great deal of deformity results and in some cases moderate disability results, but on the whole they tend to become asymptomatic even though their onset is characterized by discomfort.

2. Morbus coxæ senilis is osteoarthritis of the hip, usually in patients well past fifty. A history of trauma of some kind can usually be found in these patients and the x-ray shows a characteristic picture.



Rheumatoid arthritis, showing the involvement of the middle finger joints and the metacarpophalangeal joints

3. Hypertrophic spondylitis. Lipping and spur formation of the spinal vertebral bodies occur in most people past fifty and cause discomfort by limitation of motion and pain by pressure on nerve roots.

4. Menopausal arthritis. Women at the menopause frequently develop Heberden's nodes and pain and stiffness in the knees due to hypertrophic changes in the joints. It has been a subject of some controversy whether or not this is really a separate disease related to the menopause or merely a coincidental occurrence of menopause and joint change due to age. The discomfort usually lasts throughout the menopausal period.

Actually this classification is needless since changes are present in other joints, although one set may predominate and focus attention on them.

CAUSE OF OSTEO-ARTHRITIS

Osteo-arthritis is probably an aging process although the underlying mechanism is not understood. It rarely begins before 40 and is more common between 50 and 60. Few people beyond this age

escape from some degree of it. It undoubtedly results from the wear and tear of life and may be related to disturbances in the local circulation although this theory has never been proven. The fact that occasionally severe cases occur in younger people in their thirties signifies that there is some ill-understood metabolic change involved that is not entirely dependent on aging.

Trauma plays a great part in its occurrence. It is significant that it occurs chiefly in the weight-bearing joints of the body. Manual laborers are very likely to have enlarged, gnarled joints of the fingers and changes in the spine. Persons who use their legs a great deal are prone to have the disease in the knees and hips. Obesity, which is quite common in this group of patients, is an added handicap in two ways. It may cause faulty posture with undue strain on joints, and it adds to the traumatic factor, particularly in the knees. However, neither the idle nor the thin are spared entirely, but these groups tend to suffer less than the laboring and the overweight patients.

Frequently, the greatest handicap of

the disease is in the mental anxiety that so often accompanies it. The patient, realizing that he has arthritis, becomes terrified at the prospect of becoming a permanent cripple, bedridden, with loss of his economic value to his family. This fear results from his acquaintance with crippled arthritics who are usually, however, suffering from infectious or rheumatoid arthritis.

DIAGNOSIS

It is important to establish a definite diagnosis for osteo-arthritis before resorting to treatment because in both the medical and lay mind it is confused with infectious forms. The diagnosis is made by the clinical picture and x-ray findings. The age of the patient, the slow onset of the disease, and the location and appearance of the joints are most helpful. Rheumatoid arthritis occurs chiefly in younger people; usually many joints are involved, including the proximal finger joints, the wrists, and the elbows—which are rarely involved in osteo-arthritis.

X-ray pictures of the afflicted joints will often settle the issue when there is confusion, although these should be

studied by a competent x-ray man. The changes are usually characteristic, with bony spurs about the margins of the joint and later narrowing of the joint space and irregularity of the articular surfaces.

The most informative laboratory test is the sedimentation rate of the red blood cells. In almost all cases of active rheumatoid arthritis this is elevated above normal, whereas in osteo-arthritis, it is normal. This is a simple procedure and can be done with very little equipment in any doctor's office. A more elaborate test is the agglutination test for streptococcus which is always negative in osteo-arthritis. However, since this test is not always positive in rheumatoid disease, it does not necessarily distinguish between the two. Anemia and elevation of the white blood count do not occur in osteo-arthritis except coincidentally from some other cause, whereas inflammatory arthritis may cause either or both.

TREATMENT AND PROPHYLAXIS

There is no known specific treatment for osteo-arthritis. At present, since the

Hypertrophic arthritis, showing the Heberden's nodes of the terminal finger joints



disease is considered chiefly due to age, it seems that only certain alleviating and symptomatic therapy may be applied.

However, it is important not to inflict on the patient a number of procedures that are not helpful but which have been used rather indiscriminately regardless of the type of arthritis. It is generally accepted that removal of foci of infection does no good, and the useless removal of tonsils and teeth is to be avoided except for purposes of general health and hygiene. Vaccine therapy is not indicated and no chemotherapy has proven of any value.

Certain measures are very helpful in rendering the patient comfortable and at times even completely symptom-free. Obese patients should be reduced, in order to remove excess trauma due to weight-bearing. Rest is indicated for the same reason. Stair-climbing and excessive walking are definitely contraindicated when knees and hips are involved.

Application of heat to the affected joints is often at least temporarily alleviating. This can be applied by simple measures such as hot baths or soaks, poultices, and lamps as well as by more expensive and complicated electrical apparatus. Spa therapy is useful in that

it supplies both rest and heat in a pleasant surrounding.

Salicylates may be used freely in the form of aspirin or sodium salicylate up to 60 or 80 grains a day. Various rubefacients and liniments also provide for relief from pain.

Certain selected cases may be helped by surgery. The more severe knee joints that are unbearably painful and stiff can be helped by arthroplasty and cleaning out the excessive bone and joint mice. Recently certain hip operations have promised help but the eventual outcome of these cases is as yet questionable.

Braces, caliper splints, and other appliances may be of help if properly applied by those acquainted with orthopedic principles.

On the whole, the average sufferer can be relieved by simple measures, even if he cannot be cured, and a simple routine of rest, heat, and drugs will alleviate the discomfort of the disease. Above all, the patient should understand that the outlook is not bad and that the chances of his becoming incapacitated by hypertrophic arthritis are small.

This is the second of a series of articles on arthritis. Articles on physical therapy and occupational therapy for the treatment of arthritis will appear in an early issue.



WITHOUT the public health nurse the health officer would be as a man deaf, dumb, and blind in relation to the public he must lead to health.

We need for the nation at least twice as many public health nurses as we now employ. They will continue to be better trained. They will be increasingly trusted with the techniques, the discretions, the authority of the medical sciences, and they will remain one of the glories of freedom in the education and opportunity of women.

—Haven Emerson, M.D., *The Minnesota Registered Nurse*, March 1938.

Florida's Citizen Committees

By JEAN HENDERSON

Public health progress is dependent on enlightened citizen support and participation, and citizens' committees are a valuable channel for public understanding of health programs

THE FLORIDA State-Wide Public Health Committee, which has grown to a membership of almost twenty-five hundred in the short space of six months, is essentially a lay organization whose members are the state's leaders in civic, industrial, and educational affairs. It has the approval of the State Board of Health and includes among its members many private physicians, dentists, lawyers, and representatives of voluntary health agencies as well as lay citizens. Members of the staff of county and state health departments are *ex officio* members of the Committee without power to vote or hold office.

The foundation upon which this Committee rests is the survey of Florida health conditions made by the American Public Health Association during the first six months of 1939. Shortly after the study was started, those in charge asked that a statewide committee of lay persons be formed.

A handful of representative, public-spirited citizens met with the State Health Officer in February 1939 to discuss plans for the Committee's organization. As the survey progressed, this group became so interested in the findings and believed they were of such permanent importance to the state that in May it was decided the Committee should lay plans for permanent organization.

The original handful of people became known as the State Planning Committee of the State-Wide Public Health Committee. A retired businessman of Jack-

sonville, John P. Ingle, Sr., was elected chairman. Mrs. Malcolm McClellan, president of the Florida Congress of Parents and Teachers, was elected co-chairman.

REPRESENTATIVE GROUP

The State-Wide Public Health Committee officially took permanent form on November 2, 1939, when a constitution was adopted and officers elected. The State Executive Board decided to include the following representatives of professional and civic groups as members of the board:

President, Florida Bar Association
President, State Chamber of Commerce
President, Florida Federation of Labor
State commander, American Legion
President, Florida State Nurses Association
President and president-elect, Florida State Dental Society
President and president-elect, Florida Medical Association
President and first vice-president, Florida Federation of Women's Clubs
President and president-elect, Duval County Medical Society (location of state committee headquarters)
President, Florida Federation of Business and Professional Women's Clubs

In addition, eight members-at-large were appointed by the State Health Officer.

The objectives of the State-Wide Committee as set forth at the organization meeting are:

1. To disseminate accurate public health information to the people of Florida.
2. To assist in the organization and maintenance of full-time county health units in all counties in the state.

3. To assist in securing the adoption of recommendations in "The Health Situation in Florida," as approved and adopted by the State Board of Health.

4. To coöperate with the State Board of Health and the Florida Medical Association and affiliate with their public health programs.

The objectives of the county committees affiliated with the State-Wide Committee are:

1. To secure a survey by the State Board of Health of the health needs and resources of the county, and to assist in carrying out the recommendations presented in the survey.

2. To secure the formation of a full-time county health unit.

3. To assist the county health unit actively in carrying out its program under the guidance and with the advice of the county health officer.

4. To coöperate with and assist the State-Wide Public Health Committee in its work of disseminating information concerning public health problems in the state and in the correction of these problems as recommended in the American Public Health Association statewide survey, "The Health Situation in Florida."

FINANCING OF COMMITTEE WORK

The State-Wide Committee requires no membership dues. However, nothing in the constitution prohibits the raising of funds for a specific purpose if it becomes necessary. County committees may specify nominal dues to take care of postage and other clerical necessities if they so desire.

Several county committees raise funds for purposes incidental to carrying on the public health program in their counties. The Hillsboro County Public Health Committee recently raised \$1500 to purchase a mobile clinic for the health unit. Since no dues are required of its two hundred members, the money was raised from public contributions solicited by members. They were assisted in the drive by newspaper editors who became interested in the project.

The cost of stationery, postage, publicity releases, bulletins, and services of an executive secretary for the State-Wide Public Health Committee are borne by the State Board of Health. It also sup-

plies the services of two supervising nurses who serve the state as field workers. The committee work done by the executive secretary and the field representatives is in addition to their routine duties as staff members of the State Board of Health.

County committees receive certain supplies and services from the state office. For example, a limited amount of mimeographing service is obtainable, in addition to letterheads and membership cards for county committees. Every member of every county committee receives a copy of the state survey report and his name is placed on the mailing list of *Florida Health Notes*, the official monthly publication of the State Board of Health.

Three principles have been kept in mind in formulating a plan of organization for the State-Wide Committee:

1. The value of securing prominent lay persons as chairmen and members, regardless of whether they are or have been active in other organizations.

2. The necessity for representation from every section of the state.

3. The importance of representation from every important group—civic, professional, lay, fraternal, religious, and industrial.

THE COUNTY COMMITTEES

County committees have a minimum membership of 25, divided as equally as possible between men and women. No maximum limitation is placed on the membership. It varies according to the population. Counties with large populations may have as many as 200 or 300 members. As in the State-Wide Committee, the organization is formed on a basis of geographic and civic representation, with no area or group in the county omitted. The largest community in the county is usually the committee headquarters—which means that the county seat is not always the headquarters.

Each county committee is headed by a

chairman and co-chairman and other officers as necessary, and each has an executive board supervising its affairs. The board meets as often as necessary whereas the general committee seldom meets more than twice a year. The board determines all policies of the county committee and approves every program or project. In counties with health units the board clears all projects with the director of the health unit. Publicity must be approved by the county health officer, the State Board of Health, the county medical society, or the Florida Medical Association.

The county committee is divided into districts according to population. Each district has its own district committee and as many subcommittees as necessary. In counties with health units, the county committee uses the same districting as that used by the health unit. Thus district committees become a background for the health unit centers and subcenters.

Among the subcommittees that may be set up by a county committee are: public relations, legislation, welfare, school health, library, maternal and child health, dental hygiene, tuberculosis, sanitation, social hygiene, and communicable diseases.

Those counties that have had active county health councils or several local

councils within the county are merging with the State-Wide Public Health Committee. This is in accordance with an agreement between the State-Wide Committee and the Bureau of Public Health Nursing of the State Board of Health, which organized these councils three years ago as adjuncts to the nursing service. The merger—which has been effected in all but two counties—in no way curtails the activities of the former councils. On the contrary, it increases their scope. They continue to carry on nursing committee programs as a vital function of the county public health committees.

A manual has been prepared for the use of the county committees. It gives detailed suggestions on how to operate the committee, and also presents a graphic background of the committees' history. It is available upon request from the State-Wide Committee or the State Board of Health.

Although a membership of twenty-five hundred persons is one to be proud of, it by no means represents the potential strength of the organization. There are still a number of county chairmen who have not completed the organization of their committees. It is no exaggeration to estimate that the complete membership will probably be double the present number.

GUIDE POST FOR SCHOOL NURSES

A vocational school has tremendous opportunities to build the health of society's future workers. Page 169.

The rural nurse working in the schools needs the help of all those interested in the health of the child. Page 183.

The second part of the staff education program on eye health makes specific application to the school child and his needs. Page 197.

Increasingly nurses in official agencies are employed under a merit system. Page 144.

Every school nurse should know the symptoms of obstetrical paralysis so that she may find and refer for treatment any children not heretofore discovered. Page 187.

A VOCATIONAL SCHOOL HEALTH PROGRAM

By EMILY S. BROWN, R.N.



Walter T. Cocker, Elizabeth, N. J.

THE HEALTH services of a vocational school play an important part in fulfilling its responsibility of getting young people fit for tomorrow's job. When the Thomas A. Edison Vocational School in Elizabeth, New Jersey, opened in September 1937, the medical department was faced with a double task. It was not only charged with the responsibility for establishing a well coördinated health program, such as that carried on in the elementary and junior high schools, but also for maintaining health standards that would meet the requirements of the various trades and positions for which the students were being trained.

A vocational school has the direct responsibility of providing for its students the type of education that will best fit them to meet the ever-increasingly selective standards of the industrial and business world of today. Without the acceptance of this premise, vocational education would have little practical value and might even be foolishly extravagant for taxpayers to maintain.

In its program the school has attempted to carry out the state law regarding

A vocational school develops a health program which will safeguard the health of the students today and prepare them to take their place in the industrial world tomorrow

the requirements for students training for trades:

School districts in which all-day and part-time trade and industrial preparatory schools and classes are in operation shall maintain a medical inspection service for applicants for admission to such school and classes. The standards for such medical inspection shall be equal to those standards maintained for the examination of employees by the industries of that area.

It shall be the duty of the medical inspector to report immediately to the principal of any all-day or part-time trade and industrial school or class in the district any pupil whose physical condition may affect his safety or health while engaged in trade training, or which may prevent him from obtaining regular employment in his vocation.*

The work is looked upon as still in an experimental stage. It might not be

*New Jersey School Laws. Department of Public Instruction, Trenton, N. J., 1938, p. 228.

workable in every community. Certain factors have to be taken into consideration, such as the community's health resources, the attitude of parents, and the support and coöperation of the school administration and the board of education.

The health service has taken for a guide the following statement of the Office of Education:

Admission should be restricted to those who are physically and mentally competent to do the work and who possess the qualifications required for employment in the type of work for which the training is offered.*

HEALTH EXAMINATIONS FOR GIRLS

The examinations have been developed gradually over a period of two years. Special physical examinations for incoming students were commenced in June 1938. Since these were to be a departure from the average school examination, they were limited in the beginning to prospective students in courses offered in the girls' division, including beauty culture, commercial foods, and nursing attendants. Notices were sent to the junior and senior high schools of the city stating that students desiring to enter these courses the following September were to report to the vocational school at a specified date during June for various tests and examinations.

The physical examination for the girls includes an examination of the nose and throat, ears, teeth, heart, lungs, abdomen, and feet. The blood pressure is taken. The nurse makes the vision test and inspects the heads for evidence of pediculi. The signed consent of parents for the physical examination, including permission for a Wassermann test and a vaginal smear, is obtained for every pupil.

*Office of Education, U. S. Department of the Interior. Statement of Policies for the Administration of Vocational Education. Vocational Educational Bulletin No. 1, U. S. Government Printing Office, Washington, D. C., revised edition February 1937, p. 47.

The health examinations were made in conjunction with various other tests given by the guidance department so that pupils were accepted or rejected on the basis of the findings of these two departments. This plan proved to be an economical and satisfactory one. Of the 58 applicants examined, 37 were accepted, 11 rejected, and 3 accepted on condition pending correction of physical defects. Seven were transferred to other courses considered more suitable for them. Parents were notified of the results of the physical examinations.

In September all students of these special courses whose examinations and tests had proven satisfactory were sent to the venereal disease clinic conducted by the Board of Health at a local hospital. As new pupils registered later they were also given the physical examination at school, and the Wassermann test and vaginal smear were done by the school physician—who has been on the staff of the venereal disease clinic for many years. During the school year 1938-1939, through the coöperation of the Board of Health, 78 students were given the tests. One was rejected for the commercial foods course. Two of the students in the nursing attendants' course were advised to consult their family physicians for treatment.

Getting the girls to the clinic was a problem at first. After several girls had failed to keep their appointments, the principal arranged for groups to be transported from the school accompanied by herself or the guidance director, and the school nurse. This plan worked smoothly. The girls seemed to consider it a part of the school program and behaved accordingly.

In June 1939 there were 52 applicants for beauty culture, commercial foods, and nursing attendants' courses. There were no rejections. Four were admitted conditionally pending medical attention. Defects noted included uncorrected vision defects, flat feet, dental defects,

nervousness, acne, and curvature of the spine.

Two changes have been made in the current school year. First, the principal has added the general vocational students to the list for special examination, since these girls are trained to go into homes and they frequently care for young children. Second, tests for syphilis and gonorrhea are now being conducted entirely in the school, by the school physician. The Board of Health supplies all necessary equipment, and one of the local hospitals lends sterile goods. This arrangement is much more satisfactory than sending the students to the clinic. Considerable time is saved and greater privacy is possible. There is definite evidence of an increasing acceptance of the tests on the part of the pupils. At no time has there been any unfavorable public comment. Some students have asked to have their personal physician make the

examination. This plan is accepted by the school, provided the physician sends the specimens to the Board of Health for examination.

BOYS' EXAMINATIONS STARTED

It was not until May 1939 that extensive physical examinations were begun for boys. Previous to this time they were given the routine type of medical inspection.

The program for the boys' division grew out of a number of conferences between the Vocational Division of the State Department of Education and the school authorities—including the school physician, who presented plans and suggestions. The physician is a person of considerable industrial experience, which gives him an understanding of the health standards and practices in industrial plants. This knowledge is extremely important, since vocational education aims to train students for life



Walter T. Cocker, Elizabeth, N. J.

Measuring the blood pressure is part of the physical examination

situations. Many defects not in themselves injurious to the individual would become definite hazards in the industrial field.

The same preliminary procedures were employed for the boys' division as for the girls.' The guidance department supervised the sending of notices to the junior high schools, the distribution of parents' consent cards, the supervision of their return, and the arrangements for the examination schedule. Preparations for the examinations consumed several weeks. All boys were included regardless of the course they had selected.

The examinations, which were held in the boys' gymnasium, included the nose, throat, eyes, teeth, heart, lungs, abdomen (including examination for hernia), and feet. The blood pressure was taken. Urinalysis was done on each boy for specific gravity, sugar, and albumen. The nurse tests the vision and does the urinalysis. New boys are now given this type of examination.

Of 185 boys examined, 140 have been accepted and 9 rejected. The rest have been admitted pending medical attention and the majority of these have had defects corrected. The rejections—due to cardiac disability, hernia, vision defects, or mental retardation—have been referred to the rehabilitation commission or to a psychologist, depending on the need.

CONFERENCES WITH PARENTS

As a result of the examinations, 55 parents have been interviewed regarding defects since June 1939. This is a definite departure from the usual limited contact a vocational school has with the parents. When a parent is notified that the student's admission to the school is pending for medical reasons, he invariably comes to the school. Moreover, the correctable defects are in the majority of cases taken care of.

The interviews are held in the health room with the nurse and guidance direc-

tor. Each parent is given an explanation of the reason for these complete physical examinations. Many questions are asked and a keen interest is shown. A number of parents have to bring interpreters with them. The parent invariably links the child's health with his future economic status, which no doubt accounts in part for the favorable responses.

COÖPERATION OF DEPARTMENTS

This work could not have been carried out had there not been the complete coöperation of the various departments of the school. The program is a graphic illustration of what can be done for the health of pupils when everyone has a vision of the need. Some very useful and interesting contributions have been made by the different school departments, in addition to the administrative and guidance departments:

The physical education department helped in the collection of specimens for urinalysis and assisted during physical examinations.

The printing department printed all parents' consent cards—yellow for girls, white for boys. The trade dressmaking department made the examination capes and draw sheets. The carpentry and metal shops made some of the equipment necessary for carrying on the urinalyses.

The Board of Education was generous and prompt in purchasing necessary equipment.

The guidance departments are extremely helpful in bringing before these young people the need for sound physical health and how it will be of value in securing and holding jobs later. The close coöperation of the guidance and health departments is indispensable to the success of a vocational school health program.

Many interesting situations have come to the attention of the health service as a result of the requirements set up. Three are cited here as illustrations of the change that occurs when a vocational

school stands fast in regard to certain standards in health and teaches pupil and family that good health is related to making a living.

Lucille, a vivacious and pretty girl fifteen years of age, registered for the commercial foods course. Her voice was thick and unpleasant when she came for examination. She gave a history of frequent colds in the winter. Throughout her school life she had had enlarged, diseased tonsils. Her parents had been repeatedly notified of the defect. The father had always been indifferent in spite of the fact that Lucille had been very ill several times with tonsillitis. The school physician stated that her admission to the course was contingent on the removal of the tonsils. The parent was again approached. At first he showed the usual indifference. But finally when he realized that his daughter could not enter the course unless her throat was free from infection, a defect of at least twelve years' standing was cleared up in short order. The girl has proven to be one of the most capable commercial foods students.

John, sixteen years of age, signed up for the machine shop. He had had a serious defect in his right eye since childhood, and had worn glasses since he was six years of age, when the defect was first noted in school. However, these glasses had been obtained from an optician, and no physician had ever treated the eyes. When John found that he could not qualify for machine shop, a previous medical recommendation that he see an ophthalmologist was soon followed. He consulted a competent eye specialist who coöperated closely with the school. John was under treatment for several weeks and finally the affected eye was operated on. Today with new glasses his sight has been corrected sufficiently to meet machine shop standards. Needless to say, John is a happy boy.

A true picture of Lucy, age fifteen, could only be obtained by knowing the girl before and after her admission to the beauty culture course. She was not altogether promising material, but she had sufficient mental equipment to do the work if she would apply herself. However, she had a forlorn, unkempt appearance, and poor color. Her teeth were in extremely poor condition, with two upper canines completely black with decay. She was admitted on condition that she attend the school dental clinic—since the family was in difficulty financially.

When the time came to go to the dentist, Lucy was afraid and refused to keep her appointment. She finally decided to leave the course. She was resentful and rather ill-mannered. Since she had been a very apathetic student, she was not urged to stay. However, her mother was requested to come to the school and it was explained to her that Lucy must have the two bad teeth extracted and other necessary dental work done if she intended to take up beauty culture. The mother, an Italian woman who was scarcely able to speak English, persuaded Lucy to attend the dental clinic. The two teeth were extracted and found to be badly abscessed.

The rest reads like a fairy tale. Several days after the extractions Lucy came to the nurse to ask when she could go to the dentist again. Surprised but pleased, the nurse arranged for an immediate appointment. Lucy has continued in the course now for several months. Plans are under way to arrange for replacing the two teeth that have been lost. The clinic dentist has become so interested in her that he is willing to do the repair work for a nominal sum in his own office. The school will lend Lucy the money, which she is to repay in small weekly amounts.

The remarkable thing about this girl is the change in her attitude and appearance. She smilingly told the nurse one day, "I feel fine now." She takes great pride in her appearance and wishes to remain in beauty culture. Of course her ability will determine the future of her work, but whether she finally becomes a beautician is of minor importance. The health program has done something for this girl which it is hoped will bear permanent fruit.

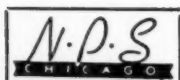
It is believed that the setting up of certain health standards has brought about other desirable results besides an incoming student body with a minimum amount of physical defects. The morale of the students has been definitely improved. There is an understanding of the physical examination, and its importance seems to be realized. The health program has tended to make them take their courses more seriously, helping them to relate their present to their future. It has given the school an opportunity to have personal contact with parents.

However, the health program is not considered a final one. As time goes on

it may be advisable to modify the plan or to add to its various features. The efficacy of the present set-up can best be judged over a period of several years. There is every reason to believe that as

vocational education widens its scope and takes its proper place in the training of youth for their life work, more and more will be expected of the health services of such schools.

NURSE PLACEMENT SERVICE



announces the following placements from among appointments made in the various fields of public health nursing. As is our custom, consent to publish these has been secured in each case from both nurse and employer.

- *Ann Hellner, Assistant Professor of Public Health Nursing, Ohio State University, Columbus, Ohio
- *Margaret Nichols, Administrative Executive, Visiting Nurses of San Diego, Calif.
- *Ann Schmich, Director, Visiting Nurse Service, Madison, Wis.
- Myrtis Ragland, Supervisor of Slossfield Health Center, Jefferson County Board of Health, Birmingham, Ala.
- *Martha Payne, Field Nurse, California Tuberculosis Association, San Francisco, Calif.
- Lillian Nelson, Community Nurse, Michigan City Chapter, American Red Cross, Michigan City, Ind.
- Grace Hull, Staff Nurse, Ingham County Health Department, Mason, Mich.
- *Edna Carlson, School Nurse, Dowagiac, Mich.
- Mrs. Jane Allen, Staff Worker, Chicago Medical School Clinics, Chicago, Ill.

ASSISTED PLACEMENTS

- *Germaine Emerson, County Nurse, Grant-Douglas Grand Coulee Health Unit, Coulee City, Wash.
- *Selma Larson, County Nurse, State Department of Health, Fort Dodge, Iowa
- Glerda Skuster, Staff Nurse, Maternity Nursing Service, Des Moines, Iowa

1939—OUR BEST YEAR

The annual report of Nurse Placement Service shows that it reached a new high peak in 1939. It handled the registrations of 3758 nurses and 3071 positions. It made 786 placements. Its number of new and reopened registra-

tions of nurses was double that of 1937. There were 5800 interviews by four professional members of the staff. The percentage increase in certain measurable aspects of the work in comparison with 1938 was as follows:

Measurable Aspects of the Work	Increased Percentage
Registration of nurses	34.3 percent
Registration of positions	19.7 percent
Placements	30.3 percent
Assisted placements	40.0 percent
Referrals of nurses to positions	14.9 percent
Incoming mail and telegrams	22.8 percent
Outgoing mail and telegrams	34.7 percent
Reference forms sent out	11.8 percent

PUBLIC HEALTH NURSING

In public health nursing there were 690 registrations of positions (22 percent of the whole) and 826 registrations of nurses (21.9 percent of the whole). There were 130 public health nursing placements, an increase of 19 percent over 1938. Also, 27 of the assisted placements were in this field. In addition, 30 placements made in the miscellaneous field had a definite public health implication.

The levels of 130 public health nursing placements were as follows: Administrative—9, education—12, supervision—24, one-nurse service—36, staff—39. The geographic distribution of candidates and positions handled by the entire service included all states in the Union, Alaska, Hawaii, and ten foreign countries. No measuring stick has been applied to the amount of vocational counseling done by the Service, but this constitutes a considerable part of the activities of N.P.S. and is a serv-

*Member of the National Organization for Public Health Nursing.

ice rendered without charge. Helping nurses to discover their interests and the fields in which they may be able to function most adequately, assisting them toward the standard preparation required, and matching their interests and skill to the kind of demand from the field is definitely a function of N.P.S. though it adds to the expense. In fact, this and careful selection by our staff of registered nurses comprise the chief differences between professional and commercial agencies.

Although at this time general business conditions in the United States are improved, placements are hard to make, especially in public health nursing. A telescopic view of the situation is expressed by Elizabeth J. Mackenzie, vocational assistant in charge of public health nursing:

In a time when there is rapidly expanding interest in health protection and growing pressure for expansion in both generalized and specialized fields, the problem of meeting the demands for adequately prepared public health nurses becomes an extremely difficult one. Add to rapid expansion a necessary raising in standards of preparation, and we have a situation that bids fair to get out of hand. Even with our courses crowded to capacity, there are not nearly enough nurses ready to take the positions which are being created. Salaries have not yet uniformly risen to predepression levels. In short, our demands far exceed our supply.

In these uncertain times one does not attempt to be prophetic. To those of us who are close to the hiring line the "state of the nation" looms in only slightly greater significance than the "state of the vocation."

ANNA L. TITTMAN, R.N.
Executive Director

PLATFORM OF THE AMERICAN MEDICAL ASSOCIATION

THE Board of Trustees of the American Medical Association has adopted the following platform which "is set up as a guide to indicate the trend which the American Medical Association believes should be followed in the development of health activities and medical care for the people of the United States."

1. The establishment of an agency of the Federal Government under which shall be coördinated and administered all medical and health functions of the Federal Government exclusive of those of the Army and Navy.

2. The allotment of such funds as the Congress may make available to any state in actual need, for the prevention of disease, the promotion of health, and the care of the sick on proof of such need.

3. The principle that the care of the public health and the provision of medical service to the sick are primarily a local responsibility.

4. The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.

5. The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.

6. In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established.

7. The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical services and to increase their availability.

8. Expansion of public health and medical services consistent with the American system of democracy.

—From *The Journal of the American Medical Association*, November 25, 1939, p. 1966.

Nursing in a Maternal Health Program

By HORTENSE HILBERT, R.N.

A discussion of the role of a public health nursing unit in a state department of health in relation to a program of maternal care

THE AMOUNTS and kinds of nursing service for which a public health nursing unit in a state department of health is responsible are naturally influenced by the economic ability of local communities to support adequate health services, the policies of state government, and the ability of state governments to provide financial and technical aid locally. Thus, the extent to which the personnel of a state department of health stands in a purely advisory relationship to the local community or actually supervises direct services given by locally assigned personnel is likely to vary from state to state.

This article will describe the role of a public health nursing unit in a state department of health, with particular reference to maternal care as part of a general plan of public health nursing. If there seems to be disproportionate emphasis on rural areas, it is because they are a more direct concern of a state department of health than urban areas, which obtain services through their own local city departments of health. However, a public health nursing unit in a state department of health should be accessible to all types of agencies administering public health nursing services within the state—official and nonofficial, rural and urban.

Also, the swing from the provision of purely educational and preventive services to the inclusion of nursing care of the sick or care at delivery and after, in the program of the official health agency,

has affected the character of the service administered through the public health nursing unit.

ADMINISTRATION OF NURSING

Several types of administrative provisions now prevail in state departments of health for making public health nursing available as part of those health services for which state departments of health are responsible.

Information from reports covering the fiscal year ending June 30, 1939, shows that in the 51 state, territorial, and District of Columbia departments of health there were:*

26 separate bureaus or divisions of public health nursing administratively coordinate with other divisions of the state department of health.

8 units of public health nursing as part of the central administration of the state department of health and serving all other divisions requiring public health nursing services.

17 units of public health nursing as part of other divisions, including 7 in divisions of local health organizations, and 10 in divisions of maternal and child health.

These figures indicate that the number of separate units of public health nursing coordinate with other divisions and the number of units which are part of the central administration are increasing, whereas the number of instances where public health nursing is part of some other administrative unit, such as maternal and child hygiene, or tuberculosis control, is steadily declining.

*Information summarized in the Unit of Public Health Nursing, United States Children's Bureau, Washington, D.C.

At present there is a definite tendency towards the broadening or generalization of public health nursing services, rather than restriction or specialization.

PURPOSES OF NURSING UNIT

The purposes of a unit of public health nursing can be said to include:

1. Insuring adequate distribution of nursing services throughout the state department of health to meet the requirements of the basic general program carried out through district, county, or other local health departments.
2. Insuring adequate amounts and quality of nursing service to meet the special needs arising out of special health conditions, such as those associated with pregnancy, childbirth, and early infancy. This means making public health nursing services easily available in amounts and kinds requested by the various divisions representing the special health services.
3. Furnishing public health nursing consultation in the planning and execution of the total program of the state department of health, as well as in the programs of the various special divisions whose services include public health nursing.
4. Supplying professional direction, supervision, and general and special technical consultation to the public health nursing personnel of the state department of health and other public health nurses, whose services come under the scope of the state agency.
5. Assuming responsibility in relation to public health nurses engaged by the state department of health as to standards of qualifications for various types of positions; selection and assignment of public health nurses; supervision—administrative and educational—for maintaining high standards of performance; and continuous education of staff through supervision, in-service training, leaves of absence for further study, and so forth.
6. Providing advice and consultation on public health nursing to local public and private agencies, as requested by them.

In short, a unit of public health nursing in a state department of health should assist locally in the development of family health services which include both nursing care and health education, at the same time that it promotes high standards of content and quality in each type of service—of which maternal care is a most important one.

What are some of the responsibilities

of a unit of public health nursing in a state department of health in relation to a program of maternal care?

In general, the unit makes a contribution by helping the local communities, through studies and surveys, to understand their maternal health conditions by means of indexes such as maternal and infant mortality rates, stillbirths, deaths during the first month of life, and so forth; by helping them to interrelate and combine private and governmental services intelligently so that mothers will get the most out of the resources at hand; by helping them view the maternal health picture as a whole, fully aware of its social and economic implications.

The unit has an obligation to bring to the attention of the state health agency and those appropriating funds to improve local health conditions, the facts about maternal health needs known to the public health nurses in the many families they visit for various health services. More specifically, some of its responsibilities are:

STUDIES NURSING SERVICE NEEDED

First, it is concerned with the amount of public health nursing which can be obtained throughout the state if the needs for maternity nursing in the previously more neglected rural and semi-rural portions of the state are to be met. Obviously, there must be a high enough ratio of public health nurses to the population, not only for educational service for the prevention of illness and the promotion of health, but also for nursing care of good quality throughout the maternity cycle.

For this it is generally estimated on the basis of experience, rather than on actual study, that one public health nurse is needed for every 1500 to 2000 population. In January 1, 1939, there were 6868 public health nurses serving the rural population of the nation¹—representing a ratio of one public health

nurse to approximately 10,000 population.

Between the years 1931 and 1939, the number of public health nurses employed in the United States has increased by 45 percent. This increase is largely the result of the use of state and federal funds to augment local funds for the extension of public health nursing. Although much of this extension has taken place in rural areas, 780 counties in the United States still have no rural public health nursing service.

Other guides for amounts of public health nursing services required—which may be used in assisting local communities to build up services adequate for maternal care—are certain quantitative criteria,² which also have evolved from experience and practice.

In regard to antepartum care, the appraisal form for local health work of the American Public Health Association indicates that community services are being covered reasonably well when from 30 to 60 percent of the pregnant women of a community are under field nursing supervision, receiving an average of at least four home visits for each woman admitted for care. Naturally it is recognized that local conditions will affect these proportions—such as the neonatal death rate, the number of women receiving regular, close supervision from private physicians, and the number receiving care through antepartum clinics or conferences.

In planning provisions for delivery nursing assistance in rural areas, all women delivered at home need to be considered, which may mean as high as 50 percent³ or more of all deliveries occurring in the area (in contrast to 25 percent or so in urban areas). The use of private duty nursing at deliveries in rural communities is so infrequent as to be negligible, although in cities about one half of the women whose deliveries occur at home have private duty nursing.

For postpartum public health nursing services, at least 15 percent of women delivered at home—each woman to receive at least three visits—has been set as a standard in the appraisal form of the American Public Health Association.

QUALITY OF SERVICE

Second, the kind or quality of maternity nursing is definitely the concern of a public health nursing unit in a state department of health.

The quality of performance in public health nursing is the product of a combination of factors, some inherent in the individual worker and some inherent in the administration of the agency by which she is employed. Personal endowments and capacities as well as general and professional education are related directly to the quality of performance. But so are the conditions of work imposed by the agency; the types and amounts of supervision provided; opportunities for continued learning; and the relationships between the public health nursing personnel and other administrative and professional personnel within the agency. The relationship between the organization administering public health nursing and all other health and social organizations is an essential factor in the public health nurses' productivity.

The administrative personnel in a public health nursing unit not only selects and recommends for appointment public health nurses qualified for various types of positions within the state agency. It also uses every occasion to assist local agencies in adopting high standards of qualifications, in finding field nurses well prepared for maternity nursing as part of the family health service, and in finding supervisors qualified to direct and teach the field nurses.

Although the subjective elements of personality, for instance, do not easily lend themselves to administrative control, there is such a thing as careful

selection of public health nurses for the job—that is, selection from the point of view of fitness for the position. The rapid extension of merit systems for personnel employed by governmental agencies will no doubt improve the general situation in this respect.

Qualification requirements⁴ for public health nurses serving in a maternal care program, either state or locally employed, at present are considered to include:

1. At least high school and preferably more advanced college or university education.

2. Graduation from an accredited school of nursing which offers thorough preparation in maternity nursing.

3. Completion of a one-year course of study in public health nursing which meets requirements of the National Organization for Public Health Nursing.

or

4. At least one year of specialized preparation in obstetrical nursing, if the nurse is employed in a public health nursing agency which provides direct nursing supervision of good quality.

General supervisors in a ratio of about 1 for 8 or 10 field nurses are necessary to the development of a sound community nursing service. In addition to the general public health nursing supervisors who carry out administrative and supervisory functions in relation to the total general service, the special consultant or teacher in the maternal and child health field is invaluable. In maternity nursing such a special worker contributes definitely toward the attainment of a higher level of performance by stimulating a greater sense of competence and assurance among the general field nurses giving maternal care and by keeping them in constant touch with educational opportunities for improving the content of antepartum, delivery, and postpartum nursing.

If the generalized plan of public health nursing through the provision of one nurse capable of providing all the services required by the family is to be successfully realized, it is of utmost im-

portance to safeguard the quality of each type of nursing service—particularly maternal care, which constitutes so large and significant a proportion of the total services of most general public health nurses.

CONSULTATION SERVICE

The public health nursing unit of a state department of health may need to provide consultation directly to local public health nurses of rural communities where the local agency obviously cannot afford to provide it, or through county or district health departments in states where such a system of local health organization exists.

The consultant in maternity nursing participates in various staff educational activities. She periodically appraises the amounts and content of service given in this field through a review of nursing records and reports. She holds individual conferences on specific problems in maternity. And she evaluates the needs and sources for further preparation in obstetrical nursing for field and supervisory personnel.

By acting as liaison agent between the units of maternal and child health and of public health nursing in a department of health, this public health nursing expert in maternal care helps to make possible more careful and intensive consideration of the health needs of women throughout the maternity cycle.

It is interesting to note in this connection the extent to which state health agencies are already providing for such nursing consultation. By June 30, 1938, there were 33 state departments of health which had appointed public health nursing consultants in maternal and child health. Of these, 21 were full-time special workers and 12 were special and general workers.

PREPARATION OF PERSONNEL

Since social security funds have become available to the states for extending and improving general public health

services and special services to mothers and children, some funds have been used for creating opportunities for further study for public health nurses as well as for other types of personnel. The public health nursing unit of a state department of health has an unusual obligation in seeing that these funds are well spent in terms of ultimate improvement of services to the family. This obligation entails the following:

1. There should be a thoughtful selection of the public health nurse who is to receive the stipend—from the point of view of ability, health, and educational background and experience. The probable length of time that she will remain in public health nursing is a factor to be considered when expenditures of public funds are involved.

It does not seem entirely reasonable that stipends should be used for making up deficiencies in the preparation of recently appointed public health nursing personnel when the qualification requirements of the health agency are far below the standards at present recommended and generally accepted.

2. There should be an equally careful choice of the program of study, depending upon the particular needs of the candidate for the service she is meant to give, rather than the accessibility of the school or a school preferred for personal reasons or one whose matriculation requirements are not as high as those of some other.

3. The potentialities of the field nurse for supervisory or consultative services are also a consideration when selecting the candidates and also when selecting the program of study, since well qualified personnel for such positions are still at a premium.

Besides the quantity of public health nursing available and its quality—which is in direct ratio to the qualifications of those giving it—a unit of public health nursing in a state department of health should be expected to assist rural

communities in definite and practical ways to provide continuity and completeness of maternal nursing care.

Health supervision and nursing care during the antepartum period have hitherto been selected for emphasis in the public health program, whereas postpartum and delivery nursing have been offered to a comparatively limited extent, particularly in rural areas.

A recent summary of home delivery nursing services made by the public health nursing consultants of the U. S. Children's Bureau in 1938 shows that nursing assistance at the time of delivery given as a result of social security provisions is guaranteed to families and physicians in 50 areas of various sizes throughout the country, one of these being an entire state. For a great many other communities these services are available to some extent, although not guaranteed, and similar services are offered by nonofficial as well as official local health agencies.

It has not been customary for official health agencies or for rural public health nurses to include so-called "bedside care" in their services, largely because of too few nurses and the irregular and time-consuming demands involved in nursing assistance at delivery, in postpartum care, and in emergency care of the sick. Now that the rural communities of the state are able to increase personnel for general and maternity public health nursing, delivery and postpartum nursing is gradually being introduced into the program. For the most part this service is still being given on a demonstration basis in small selected areas of the states because there still are not enough public health nurses, and also because of the need through experimentation to evolve policies and procedures which will be administratively applicable on a wider scale.

Several well organized, systematic demonstrations have been made and evaluated in the past two or three years.

From these the necessity for establishing some definite basic policies at the very outset of the service and of working out procedures mutually acceptable to the family, the agency, and the physicians of the community has been learned.

PROBLEMS OF DELIVERY NURSING

The inclusion of delivery nursing in a generalized public health nursing service presents special complications of administration. This service requires a larger number of public health nurses and a very flexible staff, as well as a staff well prepared for obstetrical nursing. Each visit consumes a large amount of time, about five to eight hours being the average. One delivery-nursing visit equals the time spent in eight usual public health nursing visits. Although the number of delivery visits may be proportionately small, the total time spent in this service is large. A study in a rural area has shown that 28 percent of the total time spent on maternity service was devoted to deliveries, although deliveries comprised only 6 percent of the total maternity service. Because of the irregularity of the service, provisions for night-time and over-time work are necessary.

All of these circumstances tend to increase the cost of public health nursing. However, not only its cost but also what it contributes to the safety, comfort, and relief of the mother, her child, and the family must be considered.

In the communities where delivery nursing assistance has been tried, there seems to be general agreement that it is of the greatest benefit to the mother to have two well equipped professional workers, a doctor and a nurse, assist her at the time of delivery in the home. Physicians, too, seem to appreciate the fact that expert nursing aid enables them to carry out obstetrical techniques and procedures in the home more readily and safely.

Nursing care during the immediate

postpartum period as well as health supervision is highly acceptable to mother and physician alike.

The public health nursing unit of a state department of health can be and should be of inestimable help to local agencies in developing a complete maternity service which reaches all mothers who need it, not only during pregnancy but during and after delivery as well. A well organized, comprehensive nursing service of this kind given by workers thoroughly prepared for public health and for maternity nursing to strengthen the medical and hospital facilities of a community will have its effect on the 14,000 deaths among women each year which are associated with pregnancy and childbirth, one half to two thirds of which are considered preventable; on the 75,000 stillbirths which can be reduced by two fifths, it is believed; and on the 70,000 deaths among infants in the first month of life, of which one third to one half might be saved.

Some of the policies and practices that have grown out of a rather brief background of experience and which may be employed by a public health nursing unit as a guide in consulting and advising on delivery nursing service are:

1. Provision of field and supervisory staff well prepared for public health nursing and for obstetric nursing services.
2. Adequate provisions for general supervision and also for special consultation and teaching in maternity nursing.
3. Conditions of work which will not put too great a burden of over-time work and physical strain on the field nursing staff. These include:

Arrangements for relief of nurses from over-time work; and provision for service 24 hours a day, and 7 days a week, by rotating staff nurses on call or by utilization of private duty nurses when necessary.

Compensation for over-time work by allowing equivalent time off as soon as possible.

Transportation provisions, particularly for night calls.

4. Definite policies worked out with the local physicians in matters such as the arrival and departure of the nurse with, before, or after the physician; the giving of anesthetics by the nurse; and the equipment to be supplied by the physician and by the agency.

5. Outlines of procedure: standing orders of the agency medically approved as well as orders of the individual physician attending the delivery.

6. Obstetric supplies, such as kits or packages and supplies for the newborn baby.

7. Cost and charges, if fees are collected or if private duty nurses are employed for relieving the regular staff.

8. Eligibility of mothers for delivery nursing assistance: economic status, registration for antepartum care, and so forth.

Similar consultation and help should be available from a public health nursing unit on all types of nursing included in a general family health service. But de-

livery nursing in particular has been discussed as one phase of maternity nursing because of the special administrative problems it presents when added to a health program which has comprised preventive and health education service but not care of the sick and care of women during and after delivery.

The gradual refashioning of the program and administrative structure of governmental health agencies to keep adjusted to the present economic, health, and social needs of the people is also bringing with it changes of content and emphasis in public health nursing. Remedial activities will undoubtedly occupy a more definite place in the public health program of the future and will assume larger proportions in the service of the public health nurse.

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Teamwork in a Rural Community

By SUE WILSON, R.N.

A rural nurse covering a large county uses the existing citizens' groups as channels for interpreting and carrying out the health program

WHEN THE public health nurse came to Cooper County, Missouri, in 1938, it had been without a nursing service for two years, and the community needed all the nursing services of a generalized family health program. The county covers an area of 558 square miles and has a population of 19,522. The nursing service is subsidized by the State Board of Health and is carried on according to the policies outlined by the Board. The part-time health officer is a general practitioner.

The nurse was introduced to the county demonstration agent who had been in the community a year. They talked formally, as new acquaintances will, and offered each other their cooperation. At their next meeting they thawed a bit and outlined their respective aims and programs. What an opening wedge this proved to be! The groups of women throughout the county already organized for service in the betterment of health and living conditions offered a promising channel of work to a public health worker in a new community.

Today the nursing program comprises communicable disease service, including tuberculosis control, syphilis, and gonorrhea; maternity nursing; infant, preschool, and school health service; bedside care of the sick; and service to crippled children. The home demonstration agent is the link between the nursing service and the extension clubs of the rural communities.

Each extension club has a child development chairman, who is responsible for the child health program in her club. The nurse made her first plans with the chairmen of these clubs. The women were eager to know more about what could be done for the betterment of their children. Suggestions were gladly accepted and soon there was a better understanding of the problems and the facilities for solving them.

The demonstration agent invited the nurse to attend club meetings in various sections of the county, and to explain the nursing program with its problems and possibilities, stressing the part that the members might play in making it a success. Advance newspaper notices and the introduction by the county demonstration agent made the nurse feel that she belonged to the community, that she was one of the county's citizens, and that she had a definite part to play in the lives and well-being of the people.

Letters were sent to the child development chairmen of the clubs inviting them to send the names and addresses of antepartum patients desiring literature, urging them to report patients needing the nurse's services, and encouraging them to consult the nurse at any time when her services might benefit the community. Packets of literature on infant, preschool, and school health, communicable diseases, cancer, first aid, and other subjects were delivered to the chairmen to be used as source materials for the health programs of the clubs.

The chairmen have done excellent work in the school health program, assisting with the school examinations. Parents are urged to accompany the child to the family physician and dentist for examination. Every teacher is given the health record of each child in her class. The nurse explains the health card and its use to the pupils and teacher. The card is filled out by the teacher, parent, doctor, and dentist, in the order named, and the nurse makes notes on her follow-up work. This program requires endless explanation and checking and the nurse cannot possibly do it all alone. Club women have been valuable in interpreting the school health program to the parents. Immunizations, hot lunches, first-aid kits, and other worth-while school projects are sponsored by clubs in some sections of the county.

HOME HYGIENE CLASSES

When a home hygiene class sponsored by the American Red Cross was to be started, the extension clubs were the first to be consulted. A joint meeting of three clubs was held and the formation of the class proposed. At the meeting, twenty names were signed on the class roll, names of friends were suggested as possible members, and tentative plans were made. The class was an inspiration to the nurse. The women attended faithfully all through the hot, dry summer weeks—the rural housewife's busy time. Classes were held weekly for a three-hour period in the afternoon, using a classroom in a school building. Equipment was rented or borrowed from the members. Other supplies were purchased with funds furnished by the local Red Cross chapter. Contacts of lasting value were the result of these classes and a firm basis for organization of the health work in several sections of the county was established.

At the countywide achievement day for women, one club that had completed the

course in home hygiene prepared an interesting exhibit of improvised equipment for the sickroom, thus bringing to the attention of other clubs the practical application of the class work.

LOAN CLOSETS

The clubs also worked on a county-wide project to build up a loan closet. Each club, through its council, collected supplies suitable for use in the sickroom. When sufficient supplies were obtained, they were placed in two centers in the county where they are available to any one needing to borrow supplies in case of illness. The lending is managed by a method similar to a library card system and supplies are checked in and out with certain information on the card. This service would be impossible without the help of the willing workers in the extension clubs.

"OUR NEWS"

The home demonstration agent sends a mimeographed club paper, *Our News*, to all club members once a month. The nurse was asked to add a page bringing timely health messages to club women. This page was introduced with the title "Health Notes," and is always headed by a music score with the title placed as notes thereon. The topics discussed on the page include: Hints for Hot Weather, Your Child Goes to School, Keep Well, and Outwitting Homemakers' Fatigue (excerpts from *Hygeia*). The paper is a splendid vehicle for conveying timely messages to four hundred homes in all sections of the county.

In the 4-H Club work there are certain clubs that have as their projects various phases of health. They give demonstrations in bandaging, artificial respiration, and first aid for injuries. They make ventilators, medicine chests, and various articles pertaining to the phase of health which they are studying. Good living habits are practiced as part of the project. When these clubs have



Suggestions for the daily menu

their achievement day the nurse often assists with the judging of the various teams, as well as the health posters and exhibits prepared by the clubs.

The State Board of Health coöperates with the extension service in arranging lectures for lay groups on maternal and child care.

EDUCATION FOR NUTRITION

A nutrition project is now in progress under the guidance of the home demonstration agent. In the past, relief clients who came to the courthouse for grocery orders (approximately \$3 for a family of four for a two-week period), were given no help in the wise buying of food. The demonstration agent and the nurse decided that these families were in great need of nutrition teaching. The program was planned on a long-time basis and was started with an exhibit showing a contrast between the actual foods that people buy with their order, and the

better balanced, varied diet which could be purchased with the same amount of money. It is interesting to note the number of persons who look at this exhibit in the courthouse lobby and comment on the foods, posters, and suggestions offered on placards. Each exhibit remains in place for a two-weeks' period. During this time the relief clients from the county come to the social security office in the courthouse for orders and the social case worker suggests that they see the display.

The next plan dealt with gardens, since these clients are given seeds for planting. The program is to continue with budgeting, menu planning, and the wise spending of the food dollar.

The plans like the brook go on and on forever. The demonstration agent and the nurse often go together on these sojourns into the county, planning a health program that is practical, workable, and effective. They discuss school

lunches, yard beautification, immunization, possibilities for obtaining care for an isolated invalid, or a 4-H Club project. For these are their people and it is their responsibility to help them find ways and means of better living and greater happiness. Two heads are better than one, it is universally agreed. Sharing the job is more inspiring, and brings greater joy and satisfaction. Together they see their efforts bear fruit and produce health and better living.

Organizations such as the Kiwanis, Rotary, and Lions Clubs, the Daughters of the American Revolution, the American Red Cross chapter, the parent-teacher association, the county tuberculosis committee, and various church groups are also interested in the health work of the county and have contributed materially to it.

PUBLIC HEALTH NURSING COUNCILS

In 1939 a public health nursing council was formed. Letters signed by the presiding judge of the county court—which appropriates funds to match state funds for the program—and by the nurse

were sent to persons representing service clubs and other groups in the county. An effort was made to call together a body of people from all parts of the county who were interested in better health. The meeting was called to order by the nurse and an explanation of the purpose of the council was made. A nominating committee was appointed, and the executive committee elected on its recommendation. A president, vice-president, secretary, and twenty directors comprise the executive council. The directors were assisted in forming subcommittees in their own neighborhoods.

The council meets at lunch once a month and the meeting is conducted informally as a round table. The nurse's report is given and comments are made on the nursing services. Reports from the committees are brief and are followed by a planned program. This may consist of an explanation of some health problem, a survey of present needs, or a formulation of plans.

Through this citizens' council, all groups in the community participate in the planning of their health program.

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Obstetrical Paralysis

By JAMES WARREN SEVER, M.D.

The public health nurse has a responsibility for recognizing early symptoms and securing proper medical care for this disabling condition, and often for assisting with its treatment



Figure 1

Stretching of nerves by oblique traction when the shoulder is caught under the pubes

the head delivered naturally, but the shoulders could not be delivered and at that time force was applied. (Fig. 1.)

The presentations are generally vertex or face; about a quarter are breech, the latter classification including footling presentation and also versions.

The condition of unequal pupils is probably overlooked in some cases. It is a most important symptom in that it means definite injury to the two lower cords of the plexus and the first thoracic nerve which have communicating bands with the cervical sympathetic, or injury to the spinal cord itself. The prognosis in these patients is usually not so good as in those which do not show this sign.

TYPES OF PARALYSIS

Two distinct types of paralysis are generally recognized. The more common type is caused by a lesion which involves the fifth and sixth cervical roots and the suprascapular nerve, and is a paralysis of only the muscles of the upper arm, with the exception of the supinators. This is known as the upper arm type, called Erb's paralysis. (Fig. 2.)

The less usual variety, the so-called lower arm or whole arm type, is the result of injury not only to the fifth and sixth cervical roots, but to the seventh and eighth, and possibly to the first thoracic roots as well. Here the whole

OBSTETRICAL paralysis is due to the tearing of the cords of the brachial plexus as a result of forcible separation of the head and shoulder at birth. This fact has been confirmed by operation, by autopsy, and by clinical observation. The resultant paralysis is characteristic. The arm hangs limp at the side, with the elbow extended, the forearm pronated, and the whole arm inwardly rotated. The paralysis is always flaccid.

It has been conceded by practically all observers that a difficult labor is a predisposing factor in the cause of this paralysis. The labor is usually long and difficult, with ether administered or forceps used or both. All these conditions imply the application of force, combined with great muscular relaxation of the child—conditions peculiarly favorable for the production of such an injury. A moderately large number have had

**Figure 2**

Upper arm type of obstetrical paralysis before operation. Note inability to rotate arm outwardly, to abduct, and to supinate. Note flexion at elbow

arm is flaccid. There is a wrist drop, and paralysis of the small muscles of the hand. (Fig. 3.) There occurs also, although rarely, the pure lower arm type of paralysis—known as Klumpke's paralysis—in which there is no involvement of the upper cords of the plexus. In these whole arm cases the paralysis is usually the result of stretching the plexus from overextension of the arm in head presentation, and of injury to the lower cords of the plexus—the seventh and eighth cervical roots and the first dorsal roots. The paralysis may at times be bilateral. It is in this type that one often sees inequality of pupils, owing to the fact that the sympathetic fibers from the deep cervical ganglionic plexus enter the spinal cord through the first thoracic roots and at times through the eighth cervical roots. Injury to these roots, therefore, leads to an uncontrolled stimulation of the motor oculi nerve. (Fig. 4.)

IMPAIRMENT OF FUNCTION

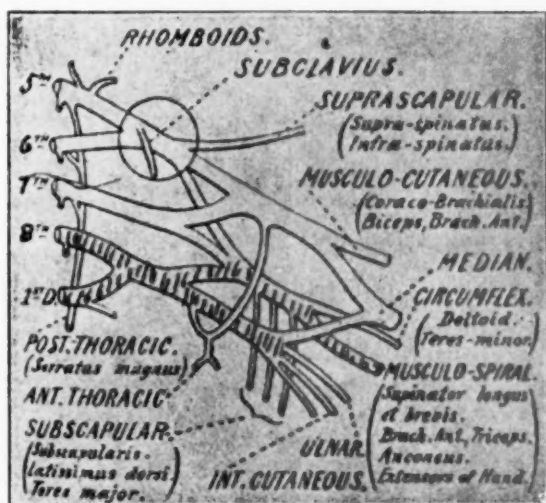
Pathologically, in the milder cases the stretching or tearing results in a greater or lesser degree of hemorrhage or edema

Figure 3

Lower arm type of obstetrical paralysis, showing right arm held in extreme internal rotation in attempted elevation, a characteristic position



Figure 4
Diagram of a brachial plexus, showing Erb's point representing the upper arm type, and showing injuries which occur in upper, lower, and whole arm types



into the nerve sheaths. In others there may be a rupture of the perineurial sheath, accompanied by hemorrhage into the substance of the nerve trunk, associated with a tearing apart or a separation of the nerve fibers. This latter condition leads, of course, to the formation of scar tissue in the nerve tract and to a permanent impairment of function. In the more severe cases of the upper arm type there is a partial or complete division of the fifth and sixth cervical roots, which leads to a more permanent form of paralysis than usual, and the formation of a more extensive area of scar tissue.

As time goes on and the child gets older, one begins to see increasing evidence of bony deformity at the shoulder, occasionally more joint subluxation (displacement) than at first, increasing outward displacement and elevation of the scapula, and acromial deformity. The deformity of the acromion consists of a bending downward and forward, or a hooking, of its outer end, which, apparently having no bony resistance to meet—as it normally does—in the head of the humerus, projects downward in front of the posteriorly subluxated and inwardly rotated head. This hooking

seems to vary directly with the degree of posterior subluxation and inward rotation of the humerus, and tends to increase as the child gets older, provided subluxation is present.

DEFORMITY AT ELBOW

Contraction of the biceps and brachialis anticus always leads to some degree of permanent flexion deformity at the elbow, and not rarely to a subluxation or even a complete dislocation of the head of the radius. The persistence of marked loss of power in the triceps is not uncommon and may be a factor in causing this condition.

Roentgenograms of the elbow practically never show any bony change of importance.

It has been suggested that the flexion deformity is due to the consequent change in shape or depth of the olecranon fossa, which consequently acts as a bony block to full and free extension. This is not so; the limitation is wholly due to contraction of the anterior elbow muscles and can be corrected only by a subperiosteal lengthening of their structures, as well as by a lengthening of the biceps tendon. Gradual stretching in a cast or turnbuckle splint might occasionally accomplish the same thing.

UPPER ARM CONDITIONS

When the child is first seen, if within a few days or weeks after birth, the following picture of the upper arm type is typical: The arm lies limp at the side, is extended, and is inwardly rotated with complete inability to abduct, elevate, outwardly rotate, or supinate. The muscles paralyzed in the typical upper arm type are as follows: deltoid, supraspinatus, infraspinatus, teres minor, biceps and supinator longus, and occasionally the serratus magnus, coracobrachialis, and supinator longus. The arm cannot actually be flexed at the elbow, but as a rule the lower arm is not affected insofar as flexion and extension of the fingers are concerned.

Shoulder

The inability to raise or abduct the arm at the shoulder is due to the paralysis of the deltoid and supraspinatus. Outward rotation cannot be accomplished because of the paralysis of the infraspinatus and teres minor, and the arm cannot be internally rotated actively because the internal rotators—namely, the teres major, the subscapularis, and the latissimus dorsi—are already fully contracted due to lack of opposition.

Elbow

The arm cannot be flexed at the elbow owing to the paralysis or weakness of the biceps, brachialis anticus, and supinator longus, and supination (turning of the palm of the hand upward) cannot be carried out because of the inward rotation in which the arm is held, and the weakness or paralysis of the biceps and supinator longus or brevis.

Sensation

In regard to sensation, it has been impossible in early cases to determine any changes from the normal because the infant is too young to describe his sensations. During the first week in early cases, the child may cry if the arm is handled or moved, especially in abduc-

tion, but this soon disappears. In one or two cases some swelling and tenderness have been noted by palpation over the plexus above the clavicle. This condition, however, apparently has no connection with the degree of paralysis present. The hand grip is usually good, and the child flexes and extends the wrist and fingers well in the upper arm types of paralysis.

Later developments

The later developments in the upper arm cases, with or without exercise and massage as the child grows older, include the following: The persistence of the inward rotation and adduction deformity; the so-called "policeman's tip" position; the inability in most cases to supinate fully or freely; the inability to get the hand to the mouth without raising the elbow, due to inability to rotate the shoulder outwardly; and the inability to put the hand to the head or behind the back.

LOWER ARM CONDITIONS

In the lower arm type, all these conditions are found, besides the additional ones due to the paralytic conditions of the lower arm and hand, resulting generally in a useless, dangling arm.

ATROPHY

Atrophy of the muscles in these patients with obstetrical paralysis is never very marked except in some cases of the lower arm type. One never sees the extreme atrophy so noticeable in cases of infantile paralysis. This lack of marked atrophy is undoubtedly due to the fact that the nerve impulses are rarely fully blocked; thus the muscles practically never, except in rare cases, lose their entire innervations. Because of incomplete destruction or injury of the nerve, some normal nerve impulses pass through the scar tissue at the site of the lesion and so keep the muscle tone up to a certain point. There is always a definite shortening of the arm

in all cases, however, probably due as much to nerve injury as to lack of use.

NERVE INVOLVEMENT

In the classification of the whole arm or lower arm type are placed those cases which show any nerve involvement beyond that usually resulting from an injury of the fifth and sixth cervical roots. Pupillary inequality and narrowing of the palpebral fissure are not unusual with this type. Wrist drop is the usual condition associated with inability to supinate, and the additional inability to extend the lower arm. Paralysis of the flexors and extensors of the wrist and fingers is common, associated with paralysis and atrophy of the intrinsic muscles of the hand. Often the proximal phalanges are hyperextended, and the distal ones flexed, due to the paralysis of the interossei or lumbricales muscles. There is, of course, no power to grip, and the fingers cannot be moved. There is usually ulnar displacement or adduction of the hand. These cases, almost without exception, represent severe tearing injuries to the roots of the plexus, and although some of the muscles may recover in part, particularly the upper arm and shoulder groups, the lower arm cases practically never recover, even after attempted operative repair of the plexus. It is in these patients that sensation is more apt to be impaired than in the usual upper arm type.

TREATMENT

First of all, the use of electricity plays no part in the treatment of these cases. All kinds have been tried and all have been given up as wasteful of time and effort.

The treatment at once resolves itself into two divisions: nonoperative and operative. Infants with paralysis of the upper arm type are treated by supporting the arm in the corrective position, and by massage and exercises. Others—



Figure 5
Plaster cast to hold arm abducted, elevated, outwardly rotated, and supinated

usually those of the lower arm type—are frequently treated by operation on the plexus. Unless the early treatment has been adequate, the upper arm type will also require operation, not to repair the plexus, but to correct contraction deformities.

At first, in order to prevent contractions of unparalyzed muscles, it is best to put the arm at rest in a position where such muscles cannot become contracted. This should be started as soon as possible after the condition is recognized. It may be done by holding the arm in a plaster cast (Fig. 5), or by using a light wire splint to hold the arm in an abducted, elevated, and outwardly rotated position, with the forearm supinated. This position should be maintained in the intervals between massage and gymnastic treatment, because it insures a better subsequent position of the arm. It also takes the drag off the paralyzed muscles, allowing them to regain their strength more quickly, and prevents subsequent shoulder joint deformity,

such as subluxation and acromial hooking.

The maternity nurse in the home sometimes discovers obstetrical paralysis in the newborn baby. In rural areas where it may not be possible to secure immediate medical care within 24 hours, the nurse who has been taught how to support the arm properly in a corrective position as described above and who has standing orders to do so may gain considerable time by starting the corrective position at once. If splints are not available, the sleeve may be pinned to the bedding to hold the arm in place.

MASSAGE AND EXERCISES

Massage and exercises are of the greatest importance and should be carried out daily if possible. It is most unwise to allow a child to become obsessed with the idea that he has an arm which cannot be used. The mother is instructed to put the sleeve on the paralyzed arm first but to undress it last. She is told that each time she takes up the baby for nursing or for other reasons, she should straighten out the fingers and wrist and supinate the forearm, as shown. Later she is shown how to abduct, outwardly rotate, and elevate the arm. One has to be guided by the intelligence and adaptability of the mother in deciding when it is wise to allow her to perform these motions. A very good rule to give her is that she is not to do anything with the affected arm that she does not see the well arm do.

Massage and exercises should be given only under medical prescription and regular medical supervision and preferably under the direction of a qualified physical therapy technician. The nurse who does not have such preparation should request the physician or physical therapy technician to demonstrate the treatment to her.

Passive and active exercises

The rhythm of exercise is of utmost importance. One will find the singing

of nursery rhymes while conducting the exercises advantageous in developing rhythm and in preventing the child from tiring of the exercise. Any suitable rhyme may be used, but it must be sung with life and enthusiasm so as to impress upon the baby the association of the song or rhyme and the movement. It is surprising how early the child learns the association of ideas.

As an example of this method, take the flexion and extension exercises for the fingers (Fig. 6). It is natural for a baby to play with his fingers, and the child should be impressed from the beginning with the fact that he has two hands.

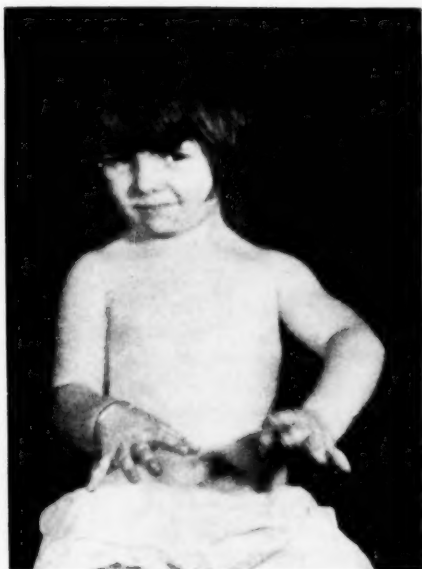
Motions for upper extremity

The child is laid on his back on a padded table and the arm or arms undressed. Beginning with the fingers and working up the arm and over the scapula, massage is given to increase the circulation and nutrition. Then each finger and thumb—first separately and then collectively—is extended and flexed. At the same time some kindergarten or nursery song is sung, such as:



Figure 6

For flexion of fingers and arm action—"Here's a ball for baby, big and soft and round"



Figures 7 and 8

For the supinators alone, showing the two active exercises, "Roll over, roll over, so merry and free"

This is little Tommy Thumb (*thumb*),
Round and fat as any plum.
This is little Peter Pointer (*index*),
Surely he's a double jointer.
This is little Toby Tall (*middle finger*),
He's the biggest one of all.
This is little Ruby Ring (*fourth finger*),
She's too fine for anything.
And the little wee one, Maybe (*fifth finger*),
Is the little finger baby.

Then, collectively:

The little birdies in their nest
Go hop, hop, hop, hop, hop.
They try to do their very best
And hop, hop, hop, hop, hop.

This is just an example of flexion and extension exercises for the fingers. To train the extensors of the wrist we sing:

This way, that way, blows the weather vane,
This way, that way, blows and blows again,
Turning, pointing, ever showing,
How the merry wind is blowing.

The emphasis is, of course, always put on the motion necessary to train the weaker muscle.

For the supinators (Figs. 7, 8), sing:

Roll over, roll over, so merry and free,
My playfellows dear, come join in my glee.

Try to have the child meanwhile actively supinate, assisted, of course, if necessary.

For flexion and extension at the elbow to exercise the biceps and triceps, sing:

Up, down, up, down,
This is the way we go to town,
What to buy? To buy a fat pig,
Home again, home again, rig-a-gig-gig.

Of course, at first, and for a long time, one must not only actively assist the child with these exercises but must also perform them while the child is passive.

For abduction at the shoulder, the position shown by Fig. 9 is used, except that the forearm is supinated. With the exercises, sing:

One yard of ribbon,
Two yards of ribbon,
Three yards, four yards,
And tie a big bow in your hair.

For elevation of the arm (Figs. 10, 11, 12), sing:

Ready, rockets! Shoot!

Repeat six or eight times. This is the same as arms upward stretch. Starting



Figure 9

For abduction at shoulder, raise arms to the level of shoulder. With palms turned up, arm extension sidewise



Figure 10

Elevation of arm—starting position for "Yards of ribbon" and "Ready rockets"

with the arms bent or flexed at the elbow, stretch them straight above the head with the palms facing each other. This is for exercise of all shoulder group muscles concerned in elevation and abduction.

For abduction at the shoulder, hold the arm externally rotated, semi-flexed at the elbow, with forearm supinated.

Figure 11

Elevation of arm—"Ready, shoot fast!"

Bringing it to full abduction and then to the body, somewhat after the manner in which the old-fashioned pump worked (Fig. 13), sing:

Pump the water, pump the water,
Pump, pump, pump.

The exercises for the upper arm and shoulder may be carried out with the child lying on his back. An older child may sit up with his back against a

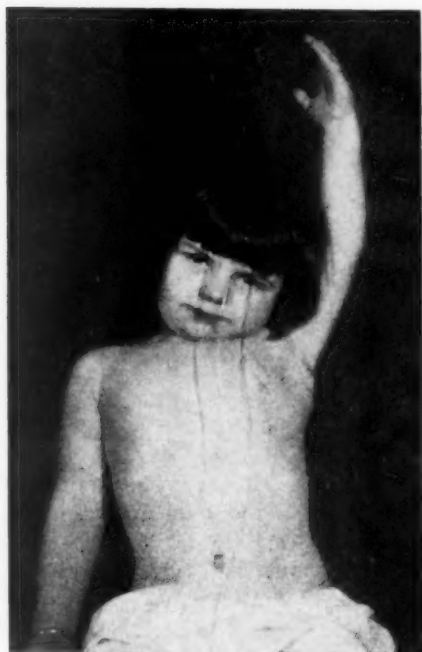


Figure 12

For elevation and abduction of all shoulder group muscles. This is the same as arms upward stretch—"Shoot!"

straight chair or wall. The scapula should always be held immovable by the hand of the operator; if this is not done, the child is apt to accomplish the desired motion by moving the scapula.

For external rotation hold the forearm flexed at right angles, with the forearm supinated and the upper arm close to the body of the child. Then carry it back till the thumb touches the table, and returning to the starting position, describing a semicircle downward, sing:

Grind the coffee, grind the coffee,
Grind, grind, grind.

While circumducting the arm, sing:

Crank the auto (up),
Crank, crank, crank.

This exercise stretches the adductors and internal rotators at the shoulder.

This covers all the motions of the upper extremity. Each case requires special emphasis on different motions.



The emphasis depends on the condition of the arm, and must be left to the operator's judgment or the doctor's prescription for treatment.

When one finds a contracted pectoralis major, subscapularis, or teres major, one must be sure to hold the scapula while elevating and externally rotating the humerus. A contracted pectoralis in a baby may be overcome by faithful treatment. The older babies and children—from one to twelve years of age—usually have contractures of the pectoralis, subscapularis, and teres major, and occasionally of the pronator teres. These cases, in addition to the treatment described, are put up in a wire splint, which fits over the pelvis and holds the humerus in a position of abduction and external rotation, the elbow in semi-flexion, and the forearm in supination. These children should be given the exercise of hanging on stall bars, or a trapeze.

Whole or lower arm

In the whole or lower arm type, it is

Figure 13

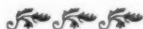
For abduction at shoulder—"Pump the water"

advisable to give three months' treatment, and if the fingers do not then show a tendency to recover, it may be well to explore the brachial plexus and repair the nerves if possible. These cases are most discouraging. No improvement is hoped for before a year of age. The writer has seen a few of these babies begin to have the slightest amount of flexion of the fingers in from six to twelve months of age, and to improve very slowly. By the end of the third year, they are beginning to build blocks. It is the consensus of nearly all the medical profession that it is useless to do any nerve surgery in these cases. When these children begin to get motion in their fingers, they are taught to build with blocks (using colored blocks two inches square), to put large colored pegs in a pegboard, and to string the large colored kindergarten beads. A child suffering from upper arm obstetrical paralysis can be taught to build blocks at five or six months of age, provided his training has been started early. After the exercises, the child is again given the

arm massage to rest the muscles.

Children naturally are imitators and live in the land of make-believe. If the operator, when treating a child between two and six years of age, has sufficient sympathy with him, she will find him of the greatest help in improvising games. All she has to do is to direct the execution of the movements so as to bring into play the muscles which she wishes to develop. When treatment has not been started until after the child is a year and a half old, the first thing the operator must do is to gain his confidence. Once this is accomplished, there is pretty clear sailing. She should never deceive a child. With tact, sufficient patience and sympathy, she can get him to try everything, and to allow her to exert considerable strength in stretching contractures.

The treatment should be continued for several years at least, and if contractures develop in the subscapularis and pectoralis major, they must be divided before any further range of action in the arm is to be hoped for.



THE FAMILY TEACHES THE "NEW NURSE"

"Well, well, a new nurse. Oh, Mabel! Show the nurse how to do things."

"Now, you just put your things here on the newspaper on this chair. Now come out here. Put your things there on the sink and wash your hands. That's the way Mrs. Surbrook does."

In the meantime, Mabel had put the instruments on to boil.

"Pa, you get yourself ready—this is a new nurse. Guess you'll have to help her out." Then Pa spoke up—

"You take that cotton in the jar with your pinchers and clean this incision off good, and then take some of them white gauze things you girls carry and put right here. Now some adhesive. The other did it this way. Well, that's just fine. Now you can go, and I'll clean these things up. Got many sick people today? Well, this is good weather for pneumonia, ain't it? No snow yet."

The nurse finally managed to get a goodbye said and was off to the next case.

—From *The Visiting Nurse*, Detroit, Michigan, January 1938

A Program for Staff Education

Eye Health

By ELEANOR W. MUMFORD, R.N.

PART II

RELATION OF EYE PROBLEMS TO SPECIFIC HEALTH SERVICES AND AGE-GROUPS

Since many ocular disturbances originate in systemic diseases, the general health services are of the utmost importance to the protection and promotion of eye health. However, since any visual disturbance may have serious repercussions—mentally, emotionally, and physically—the protection of sight forms a vital part of any program which aims to promote the health of the whole being.

The correlation of data on normal and abnormal eye functioning with specific health services or the age-groups most commonly affected serves to emphasize the relationship of eye health to the entire health program.

I. MATERNAL AND NEWBORN CARE

Eye development starts very early in the life of the embryo, and although the structure of the eye is complete at birth, growth and development continue afterwards. Arrests in development or overdevelopment of any particular part of the eye may occur during embryonic life, giving rise to "congenital abnormalities." To what extent these may be due to disturbances of the mother's general health is not known. (Ref. 17, p. 1037; ref. 4h.)

Studies indicate that nutrition is an important factor in the maintenance of eye health. Optimal nutrition for mother and child requires increased intake of protective foods during pregnancy and lactation. According to Rose, the vitamin-A requirement is doubled during

these periods. (Ref. 11, pp. 522-527 and p. 596.)

Of the children in 29 schools and classes for the blind, 40 percent were born blind, while another 19 percent lost their sight in the first year of life. (Ref. 20.) In this same group, 47 percent of the cases were attributed to prenatal or hereditary factors. (Heredity could be established in only 34.6 percent of the cases.) Ophthalmia neonatorum accounted for another 10 percent, and congenital syphilis for 4.5 percent. (Ref. 8.)

Ophthalmia neonatorum is almost entirely preventable with proper prophylaxis. Silver nitrate in wax ampules is considered the most effective prophylactic agent and the safest method for distribution and instillation. If infection occurs, prompt medical and nursing care are essential to save sight. (Ref. 2, pp. 40-44.)

Toxemias of pregnancy manifest retinal changes which may be evident before clinical symptoms appear. Thus, ophthalmological examinations in pregnancy may be an important step in the early diagnosis of toxemias. (Ref. 10, 4g.)

Study suggestions:

Review the maternity program in relation to the above data considering especially the following points:

How early in pregnancy are prospective mothers registering for care?

What percentage of mothers receive diagnostic tests for syphilis before the fifth month? How adequate is follow-up of infected cases?

Is examination for gonorrhea routine for prenatal patients and is treatment instituted?

Review procedures relating to the prevention and control of ophthalmia neonatorum, considering especially the following points:

What medically approved standing orders are used for emergency care in suspicious cases?

Is legislation adequate?

What nursing techniques are involved in prophylaxis and care? (Demonstrations are desirable.)

How important is the maintenance of general health when infection occurs?

How can the nurse's or attendant's eyes be protected from contamination during treatment? (Ref. 2, pp. 40-44; ref. 4f; ref. 3, p. 115.)

II. INFANT CARE

Eye structure is complete at birth but the eye is not full-sized; hence, an infant's eyes are hyperopic, and—despite very active accommodative powers—are adjusted for distant rather than close vision. Pigment is scanty at birth, so the eyes are sensitive to bright light but the lids and pupils usually form adequate protection. During sun baths the feet should be pointed away from the sun to permit the brows to aid in shading the eyes.

Eye muscle coördination develops as the eyes are used. Attempts to direct the gaze start in the first weeks after birth. Such efforts, feeble at first, should develop into coördinated use of the two eyes together by the end of the first year. Ophthalmological examination and care are indicated if there is any sign of deviation from normal after this time, or earlier if coördination does not appear to be developing. (Ref. 4h.)

Contamination and infection of the eyes through careless handling are not uncommon. The lids should be bathed with the rest of the face, but care should be exercised to prevent water from

getting into the eye. Inflammation or a discharge requires prompt medical and nursing care to prevent damage to the eyes. When infection occurs, the maintenance of general health helps to build up body defenses. (Ref. 2, p. 40.)

Study suggestions:

Review procedures on infant care in relation to the prevention of infection, the protection of the eyes from bright light, and the giving of sunbaths.

Outline teaching for mothers in regard to care of the infant's eyes.

III. CARE OF THE PRESCHOOL CHILD

The preschool child is usually hyperopic (farsighted). But having adequate power of accommodation, he can adjust to close work for brief periods although continued close work creates strain and fatigue because of the increased muscular activity. (Ref. 4a, 4h.) There is continued and finer development of coördination of the two eyes, and fusion of the images seen by the two eyes develops during the preschool years. However, visual defects—especially those involving differences in the visual acuity of the two eyes—may interfere with the normal development of coördination. Because such differences are irritating, the child is likely to suppress the image seen by the poorer eye and use only one. The poorer eye usually becomes weaker and turns in, creating an obvious strabismus, which tends to make the child supersensitive. Early correction of the defect is important from the emotional point of view and essential to the development of fusion and to saving the sight of the weaker eye. (Ref. 4d.) (See also disturbances involving external eye muscles, February, p. 116.)

The Snellen test can be used to aid in the discovery of visual defects with children as young as two and one-half years. Such tests should be used regularly

throughout the preschool years. (Ref. 4c.)

Sharp toys and explosives cause many preschool children to lose one or both eyes.

Certain acute communicable diseases common to this age such as measles, scarlet fever, and meningitis sometimes cause eye manifestations which may result in blindness or seriously impaired sight. It is important to be alert to eye manifestations during any acute communicable disease and to prevent excessive close work during convalescence.

Interstitial keratitis, due to late-developing congenital syphilis, occurs usually between the ages of 5 and 25 years. It is characterized by severe watering of the eyes, extreme sensitivity to light, and pain in the eyes. Permanent damage to sight may result.

Styes and inflamed or crusted lids may be due either to nutritional inadequacies or to poor hygiene. Nutritional deficiencies may also cause certain inflammations of the cornea and inadequate adaptation to the dark. (Ref. 4i.)

Study suggestions:

Outline teaching for parents regarding:

Care of the eyes in illness.

Safe and dangerous toys.

Observations which may indicate visual defects.

Reasons for early ophthalmological care of defects.

Demonstrate and practice giving the Snellen test to preschool children.

IV. THE CHILD OF SCHOOL AGE AND SCHOOL HEALTH SERVICES

Children of school age are usually hyperopic, but as the eye gradually lengthens from front to back, the degree of hyperopia diminishes. Normally children have such active accommodative power that reasonable periods of the types of fine work connected with school and play activities should occasion no discomfort. (Ref. 4h.)

A small percentage of children are myopic at birth, and as elongation of the eye progresses, become increasingly so during the school years. Early discovery and correction of this condition is extremely important since it may develop into a serious handicap or it may be a pathological form of myopia. The incidence of myopia tends to increase quite rapidly up to 14 years of age and less rapidly after that. (Ref. 12.)

A. Treatment of inflammatory conditions

Inflammatory conditions within the eye or of the cornea, sclera, conjunctiva, or lid margins occur in children and may be secondary to focal infections or to communicable or non-communicable systemic diseases. Poor personal and environmental hygiene and nutritional deficiencies may be contributory factors. Every inflamed eye should be considered serious, and warrants medical attention. (Ref. 4i.)

B. Prevention of injuries

Sharp-pointed toys and explosives are serious hazards to children's eyes. Of the blindness in children, 9 percent is due to injury. (Ref. 8.)

C. Periodic eye examinations

Since education relies greatly on the use of the eyes, clear visual images and the coordinated use of the two eyes may be very important to school progress and to the social life of the individual. Early discovery of visual defects and aid in securing medical diagnosis and treatment for them and for other ocular disturbances are accepted functions of the school. Periodic eye inspection and vision testing should form an educational experience for the child, and should be correlated with daily practices at school, home, and play, and with teaching parents and children the proper use of community resources for eye care. (Ref. 4c, 4m.)

D. Environmental conditions

Providing environmental conditions

that are conducive to the safe, comfortable, and efficient use of the eyes is a further responsibility of the school and of the family. Such conditions include:

Safeguards to prevent injuries to the eyes, and safety devices as needed for particular activities such as shop work, laboratory work, and games.

Adequate and properly adjusted light to meet the needs of individual children for the comfortable and efficient use of the eyes. The minimum intensity recommended is 15 foot-candles on every working surface. (Ref. 13, p. 11.)

Walls and working surfaces free from glare and deep shadows.

Printed materials and other types of working materials selected with due consideration for the eyestrain involved when used by children.

E. Adjustments for visually handicapped children

The school has a responsibility for meeting the needs of visually handicapped children. About one school child in five hundred is estimated to be in need of special educational and environmental adjustments because of visual handicaps. While special arrangements can be made in the regular classes, these adjustments are often made through sight-saving classes where the size of the group warrants such a plan. Admission to these classes is on the basis of recommendations by an ophthalmologist, but in general, it is believed that special adjustments are needed for children who have the following conditions:

Visual acuity of less than 20/70 in the better eye with the best correction, or seriously limited fields of vision.

Ocular diseases which are progressive in nature.

Any other eye conditions either temporarily or permanently requiring adjustment of educational methods. (Ref. 4l.)

Study suggestions:

Review case-finding methods and community resources for correction and care. (Ref. 4c.)

List types of behavior which may be indicative of visual defects and observe

a group of children to note the presence of such signs. (Ref. 4c.)

Visit a sight-saving class. Observe the equipment, and talk with the teacher about the types of eye problems in her class and the mental hygiene aspects of her work. (Ref. 4l.)

Review the teaching to parents and teachers regarding children's eyes, including a discussion of safe toys. (Ref. 4k, 4m, 4j.)

Plan a lesson on eye safety in connection with play and school activities.

V. ADULT HEALTH SERVICES

The incidence and severity of visual defects tend to increase during adult life, especially after middle age. Some of the causes for this increase are normal physiological changes in the eye (presbyopia); systemic diseases which affect the eye; and eye infections or injuries.

There appears to be a higher prevalence of visual defect among college students than among industrial workers in the same age-group. The number of such defects in college students also shows considerable increase during the four years of college life. Several factors may be involved in this, such as the tendency of myopic individuals to select close work; the extreme amount and the long periods of near vision required in college with lack of proper consideration for adequate lighting, posture, and rest; and some of the visual defects may represent eye manifestations of systemic disturbance. (Ref. 4o, 9.)

A. Normal physiological changes in the eye

Presbyopia, with its reduced power of accommodation, is usually noticed between 40 and 45 years of age. The only symptom generally noticed is the inability to accommodate for close work. (See also refractive errors, February issue, p. 115.) (Ref. 4t.)

B. Systemic diseases which affect the eye Systemic diseases and disturbances

which in adult life tend to produce eye manifestations are

- Brain tumor.
- Cardiovascular diseases.
- Communicable diseases, especially syphilis, gonorrhea, and tuberculosis.
- Chronic poisoning and intoxications.
- Diseases of the nervous system.
- Infections (focal and systemic).
- Metabolic disturbances.

The effects of these conditions upon the eye vary. In some cases the ocular manifestations may be the first symptoms of the underlying condition; in others, the eye disturbance may be delayed. Periodic physical examinations, including careful examination of the eyes, are an important factor both in the prevention of eye conditions arising from these causes and in the early discovery of the systemic disturbances.

The eye conditions resulting from systemic diseases may be so severe and of such a nature that eye work is impossible. But in every illness, even where no eye symptoms are apparent, the amount and type of eye work should receive careful consideration and close observation should be maintained for such symptoms as:

Visual disturbances, including sudden or gradual decrease of vision, blurred vision, seeing more than one image, changes in ability to distinguish colors, rings, or halos around lights, dark areas in the field of vision, a narrowing of the visual fields.

- Pain in or around the eyes.
- Headache.
- Changes in reaction to light—marked increase or decrease in sensitivity.
- Red or inflamed eyes or lids.
- Discharge from the eyes.

C. Eye diseases

Two eye diseases are sufficiently common in adult life to warrant special consideration here: cataract and glaucoma.

Cataract

Cataract may be defined as an opacity of the lens or its capsule. In children, cataracts are frequently congenital; in adults, frequently senile (due to a de-

generative change in the lens). Both eyes are usually affected unless the origin of the cataract is injury to one eye only. It is not always possible to determine the cause of cataracts but contributory factors may be:

- Heredity.
- Injury or irritants, including extreme heat.
- Diabetes, nephritis, arteriosclerosis.
- Vitamin deficiencies.
- Other ocular diseases which interfere with the normal nutrition of the lens.

Such opacities are quite common after middle age. The amount to which sight is diminished depends on the extent, location, and density of the opaque area. Symptoms include diminished vision, sometimes spots before the eyes, and seeing more than one image.

Cataracts are considered one of the most hopeful eye diseases of advanced years, since they are operable, and following operation—unless there is damage to other parts of the eye—the vision can be corrected by glasses. (Ref. 4p.)

Glaucoma

Glaucoma is a progressive eye disease occurring most frequently over fifty years of age. It is characterized by increased tension within the eye resulting in destruction of the nerve endings in the retina. Primary causes are not definitely known, but secondary causes and contributing factors are:

- Cardiovascular disease.
- Gastrointestinal infections.
- Inflammatory conditions within the eye.
- Emotional upsets.
- Heredity.
- Eyestrain from overuse of eyes with uncorrected visual defects.

Symptoms include increased ocular tension, narrowing of the field of vision, cloudy or diminished vision, halos around lights, reduced sensitivity to light, and—in the acute stage—severe pain and redness. The onset may be sudden or slow, and considerable damage may occur before symptoms are noticed by the patient.

Prompt and skillful medical or surgical treatment is required to save sight.

Emotional upsets may have serious results. Patients are frequently tense and irritable. Keeping them calm and happy and building general health are important factors in arresting the disease. (Ref. 4q.)

D. Eye injuries

Each year approximately 300,000 industrial eye accidents result in the loss of one or more days' work, and at least 2000 people lose the sight of one eye from such injuries, while probably seventy-five more are blinded in both eyes. Sight is also lost through such industrial hazards as prolonged exposure to heat or radiation; the ocular results of industrial poisoning; and dusts or other irritants. Proper protective devices, and skillful first aid followed by prompt ophthalmological care would prevent most of this loss. (Ref. 15, 4u.)

Many eye infections are due to faulty first-aid procedures in attempting to remove foreign bodies from the eye. Others, such as certain types of conjunctivitis, are due to contamination of the

eye. (See communicable diseases, February issue, pp. 114, 115.) Personal hygiene, prompt isolation of infected persons, and prompt ophthalmological care are necessary to prevent the spread of these infections and to limit the damage to the eye. (Ref. 2, pp. 31-40.)

Study suggestions:

Discuss and outline the application of the foregoing data to:

The care of the nurse's own eyes.

The eye health of college students. (Ref. 4n.)

Eye health in industry. (Ref. 4u.)

General health services, medical or venereal disease services.

Discuss the relation of systemic diseases to eye health:

List common eye manifestations of important systemic diseases and their early symptoms.

Review teaching to patients regarding use of the eyes in illness and convalescence.

Review state regulations regarding safety and lighting in industry.

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See February issue, pp. 120, 121, for bibliography.

(Concluded)



News from the S.O.P.H.N.'s

ARKANSAS, located on the west bank of the Mississippi River within a few hundred miles of the Gulf of Mexico, is a rural state covering about fifty-three thousand square miles. Although one fourth of its two million inhabitants are Negroes, the proportion ranges from as high as eighty percent Negro population in some sections of the Mississippi Delta to none in the north and west Ozark Mountain counties. The people of the state earn a living in numerous industries, from the mining of bauxite to "bathing the world with the healing waters" of Hot Springs. Cotton farming is the principal occupation.

In 1920 a few public health nurses, most of whom were employed by voluntary agencies, were scattered over the state. In September of that year, fifteen of the nurses met in Little Rock and organized themselves into the Arkansas State Organization for Public Health Nursing. This organization functioned independently until 1929, when its members petitioned that it serve as a section of the State Nurses' Association. The affiliation, effected at that time, still exists. Closer cooperation with the Association and the State League of Nursing Education has resulted.

During the early days, the S.O.P.H.N. in its program kept before its members and those of the State Nurses' Association the opportunities for qualified nurses in public health nursing.

In 1937, the board of directors gave consideration to certain factors in planning the program. They realized the need for the interest and participation of the laymen in the public health nursing program. With the exception of the board of the Visiting Nurse Association of Greater Little Rock, no active advisory boards existed. Hence, the organization had no lay members. Many of the nurses expressed a desire for

information on ways in which they might utilize the services of the laymen. The organization had accumulated a small fund which could be used for the benefit of all its members. As a result, an educational program was decided upon.

INSTITUTE ON LAY PARTICIPATION

The Education Committee conferred with representatives of the National Organization for Public Health Nursing regarding our needs, and through its cooperation an institute on lay participation was planned. Valuable assistance in the planning was given by the board of the Visiting Nurse Association of Greater Little Rock, and by the State Board of Health, which employs 86 percent of the public health nurses in the state. In September 1938 a two-and-one-half-day institute was conducted by Evelyn K. Davis, assistant director of the N.O.P.H.N. Three sessions for professional workers and three for board members were held, and a period was given to individual conferences. The lively discussions in the meetings indicated an interest in the subject. The attendance exceeded all expectations. Ninety-four nurses and medical directors came from 59 counties, and 68 lay workers represented 13 counties. Representatives of the State Board of Health and executives from many voluntary health and social welfare groups also attended.

After the institute, the board decided that further assistance and stimulation for the organization of advisory health committees might be worth while. Two activities were inaugurated. First, an outline—prepared by Miss Davis—listing the steps to be followed in planning for and organizing a committee was sent to all nurses in the state. Second, 15 regional meetings were held, to which nurses, medical directors, and representative laymen of the various clubs and

communities were invited. The purpose of these meetings, in addition to encouraging the organization of advisory committees, was to call the attention of professional and lay workers to the contributions being made by various local groups to the improvement of health conditions in the communities, and to show the opportunities presented for coöperation.

Members of the S.O.P.H.N.—who were also district nursing consultants in the State Board of Health—presided at these meetings. The attendance and participation were beyond expectation. Many county judges, mayors, state representatives, and private physicians, in addition to representatives of community organizations, were present. Numerous requests for similar meetings to be held annually were received.

LAY ADVISORY COMMITTEES STARTED

Definite results of the educational program arranged by the S.O.P.H.N. have been noted. There is a better understanding of the function of the local health departments and the health activ-

ities carried on by local voluntary groups; a closer coöperation of lay and professional workers in most of the counties of the state; and increased interest in the organization of advisory committees. In from 15 to 20 counties of the state definite steps have been taken to organize such committees. The board of the S.O.P.H.N. anticipates an increased number of lay members in the organization.

The objectives for the coming year, as listed by the new board, are:

1. To stimulate further the organization of advisory health committees in health agencies.
2. To coöperate with the State League of Nursing Education through a joint committee to study and make recommendations on the amount of public health nursing offered in the schools of nursing in Arkansas.
3. To prepare recommendations for minimum qualifications of public health nurses, for the guidance of agencies, in employing public health nurses.
4. To prepare a history of public health nursing in the counties and the state.

LILA SALLEE, R.N.

*President, Arkansas State
Organization for Public Health Nursing*

Your N.O.P.H.N.

An Irishman who had his first sight of cranberries asked his more experienced brother if they were fit to eat. "Sure," he said, "them cranberries make better applesauce than prunes do." The results of our attempts to isolate the N.O.P.H.N.'s program on education from the rest of our service are almost as complicated. Well prepared supervisors develop better staff nurses when the agency has understanding administrators. Staff nurses adequately prepared in orthopedic, school, and industrial nursing make better nurses for well prepared supervisors to guide. It does

seem complicated, doesn't it? But preparation for the job—whatever it may be—is the thread which runs through all aspects of public health nursing.

The Education Committee of the National Organization for Public Health Nursing has considered its responsibility toward all of these workers and toward all phases of the public health nursing program, and believes its functions to be as follows:

1. It determines what qualifications are essential for nurses in each of the various types of positions and kinds of

services, in order to enable them to carry out the required functions.

Toward this end, at the beginning of each five-year period the Education Committee with the cooperation of the Committee on Professional Education of the American Public Health Association presents what may reasonably be the minimum qualifications for public health nurses employed during the next five years. In 1939, such qualifications were set up for school nurses, industrial nurses, and those engaged in orthopedic programs. Just now, public health nursing agencies all over the country have been asked to compare the actual qualifications of their staff members with the minimum qualifications for 1935-1940 and to let us know how nearly they reach these standards and what are the difficulties in finding nurses to meet them. This information is to help the committee determine the new goals to be set for 1940-1945.

2. The Committee sets standards for colleges and universities preparing nurses to meet these qualifications and provides advisory service to assist in their attainment.

Nurses want to be sure that the preparation they get is of acceptable standard. Employers need help in evaluating the qualifications of the nurses they employ. Early in its career, the N.O.P.H.N. recognized that it was the only organization ready at that time to set standards for programs of study in public health nursing and to apply those standards to such programs in order to issue an approved list for the guidance of nurses and their employers. Many of the Education Committee's activities are centered around this function.

3. In cooperation with the National League of Nursing Education, the Committee makes recommendations regarding desirable practices in the affiliation of schools of nursing with public health nursing agencies.

This has become a burning problem

because of the large number of students, both graduate and undergraduate, for which such experience is desired. Too few public health nursing agencies are able to provide adequately for such experience. Necessary limitations of numbers of students and the cost of providing supervised student experience make it necessary to consider the whole problem seriously. In what other ways can the student get a concept of health conservation, disease prevention, and the community and family aspects of health? How can the public health facilities in the community best be used to give the student this understanding? What is the relationship between the cost of the student to the public health nursing agency and her contribution to the agency? These are problems now facing the N.O.P.H.N. as well as the National League of Nursing Education, and both organizations are giving these problems serious consideration.

4. The Committee studies supervision and staff education programs and makes recommendations regarding them.

This function of the Committee involves not only keeping up with the practices in the public health nursing field, but also being familiar with changing concepts and methods in teaching and supervision in other fields as well. Supervisors and administrators everywhere say to us: "We are revising our activity records. Can you give us suggestions?" Loan folders containing helpful material and selected forms used by other agencies have been popular. Similar loan folders are available for those asking questions about staff education and student programs. A subcommittee is now considering what the university should offer the public health nurse to help her secure preparation for the job of supervision.

The educational secretary has the responsibility of helping the Education Committee to carry out all of these functions. She it is who must keep an

ear to the ground, through field visits, conferences, and correspondence, in order to bring your problems to the committee. That's no small task in view of rapidly changing functions of public health nurses and expanding educational programs everywhere.

Coördinating the work of various subcommittees of the Education Committee with that of other committees of the N.O.P.H.N. and with committees formed jointly with other agencies is a major part of the secretary's job. Members of the Education Committee are serving on anywhere from two to five subcommittees, studying different aspects of public health nursing education. They serve also on committees of the National League of Nursing Education and the Association of Collegiate Schools of Nursing, for the N.O.P.H.N. and these two organizations have much in common. To keep the lines untangled and the way clear of duplicating activities between these committees becomes the duty of the secretary.

Interpretation of the standards adopted by the Committee is especially necessary in relation to the requirements for programs of study in public health nursing. Advisory visits are often made before a university program is started, so that plans can be developed in the light of the requirements for adequate theory and practice. The secretary keeps in touch with developments. When a program of study seems to be meeting the requirements, the secretary visits the university upon its formal request,

to review the situation and to formulate a report for the Education Committee. Upon the basis of this report, the committee determines whether the university is to be placed on the approved list of programs of study in public health nursing. These visits also give opportunity to gain an understanding of the practical problems in the preparation for public health nursing and also to share helpful information gleaned from contacts with other universities and their attempts to meet their problems.

Maimonides, great Jewish philosopher and physician of the twelfth century, wrote that success is the synthesis of four elements—good material with which to work, a good plan according to which it may be fashioned, good technique in the execution of the plan, and finally a good objective.

Toward all of these the educational program of the N.O.P.H.N. is striving—careful selection of nurses for public health nursing, a sound program of theory and supervised experience for those who choose to enter the field, high educational standards in universities and field agencies providing such programs, and finally the objective of developing to the highest degree in each public health nurse her potentialities for service in that field.

VIRGINIA A. JONES, R.N.

This is the seventh of a series of articles on the National Organization for Public Health Nursing, written by the president and members of the staff.



NOTES *from the* NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

THE ANNUAL MEETING

THE ANNUAL meeting of the Board of Directors of the N.O.P.H.N. was held on January 29, at the Hotel Roosevelt in New York City. The following states were represented by the Board: Alabama, California, Colorado, Illinois, Michigan, Minnesota, New Jersey, New York, Ohio, Pennsylvania, and the District of Columbia. Attending as guests were delegates to the Council of Branches from the following states: Arkansas, Georgia, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Montana, New Jersey, Oklahoma, Oregon, Pennsylvania, Rhode Island, Tennessee, Texas, Utah, and Washington. In addition, the chairmen of our three sections were present: Mrs. Frederick S. Dellenbaugh, Jr., Board and Committee Members' Section; Joanna Johnson, Industrial Nursing Section; and Marie E. Swanson, School Nursing Section. All the executive staff of the N.O.P.H.N. were present.

The general director's report gave some of the important developments in the year's program of the N.O.P.H.N. and in the field of public health nursing. Highlights from her report in outline form are as follows:

Organization of N.O.P.H.N. Council of Branches.

Organization of Advisory Committee on Lay Participation, Wilson G. Smillie, M.D., chairman.

Initiation of vocational counseling service and assistance to the Advisory Committee on Vocational Counseling through the appointment of Ella L. Peninger as assistant director.

Final approval of Nursing Bureau of Manhattan and Bronx, New York, N.Y., for public health nursing placement service.

Promise of a study of the curriculum in public health nursing in colleges and universities, with the help of the U. S. Public Health Service, to begin February 1, 1940.

Publication of *A Study of the Services and Support of Eleven National Agencies*—a study of national dues in chest cities made under the auspices of the National Social Work Council, which was sent to all agency members of the N.O.P.H.N.

Completion of study of tuberculosis records with help of the Committee on Administrative Practice of the American Public Health Association. Report to be published.

Publication of "Desirable Qualifications of Nurses Appointed to Public Health Nursing Positions in Industry" in July PUBLIC HEALTH NURSING.

Resignations from the N.O.P.H.N. staff of Ella E. McNeil, assistant director in charge of school nursing, and Mabel Reid, assistant statistician. Replaced by Anna C. Gring, assistant director, and Louise Hopwood, assistant statistician.

The First American Congress on Obstetrics and Gynecology, Cleveland, Ohio—Nursing program planned under guidance of the N.O.P.H.N., by Ruth Houlton.

Discontinuance of work of executive secretary for Joint Committee on Community Nursing Service, Lulu St. Clair.

Initiation of orthopedic nursing project with help of National Foundation for Infantile Paralysis through appointment of Jessie L. Stevenson as consultant in orthopedic nursing.

Publication of revised edition of *Manual of Public Health Nursing*.

X-ray pictures of clerical staff completed; all medical examinations brought

up to date; all staff vaccinated in June because of smallpox in New York State.

N.O.P.H.N. agency members December 31, 1939—351.

N.O.P.H.N. individual members December 31, 1939—10,351.

Number of agencies having entire nursing staff enrolled as individual members—Honor Roll agencies—December 31, 1939—948.

The Board accepted the recommendations of the Finance Committee and adopted a budget of \$114,311, which includes the orthopedic nursing project supported by the National Foundation for Infantile Paralysis. For the financial report for 1939 see page 210.

One of the most important actions of the Board was to accept and recommend for acceptance of the membership at the Biennial Convention the new requirements for agency membership. (See PUBLIC HEALTH NURSING, November 1939, page 637.) Since these requirements call for revision of the by-laws, they will be voted upon by all members of the N.O.P.H.N. in good standing on May 14, 1940. Each member will receive these revisions in April.

Since this is a Biennial Convention year, two-year reports of all activities of sections, councils, and committees will be published in May. Only the highlights of recent activities, therefore, are given here.

The Education Committee reported the appointment of a subcommittee to work on the 1940-45 revision of the minimum qualifications for appointment to positions in our field. Also, the new advisory committee to work with Mary J. Dunn of the United States Public Health Service on the study of the curriculum in programs of study was announced. Its members are as follows:

Reginald M. Atwater, M.D., Dr.P.H., representing American Public Health Association

Mary Beard, representing American Red Cross

*Eula Butzerin, representing Curriculum

Committee of Association of Collegiate Schools of Nursing

Roy J. Deferrari, Ph.D.

*Mayhew Derryberry, Ph.D.

*Naomi Deutsch, representing Children's Bureau

Harold S. Diehl, M.D.

Lula Dilworth, representing school nursing interests

Rena Haig

Lilly Harman

Marion G. Howell

*Ruth W. Hubbard, representing N.O.P.H.N. Education Committee

*Louise Knapp

*Joseph W. Mountin, M.D., representing U. S. Public Health Service

*Blanche Pfefferkorn, representing National League of Nursing Education

Mrs. Corinne N. Sawyer, representing National Association of Colored Graduate Nurses

Isabel M. Stewart, representing Association of Collegiate Schools of Nursing

*Katharine Tucker, representing Collegiate Council on Public Health Nursing Education

Mrs. Abbie R. Weaver

Ex officio members—* Thomas Parran, M.D., *Pearl McIver, *Grace Ross, *Dorothy Deming, *Virginia A. Jones

The Education Committee reported the approval of the following programs of study in 1939, as of January 31, 1940: Indiana University, Bloomington, Ind., Mrs. Bessie Swan, instructor and supervisor in nursing education; Marquette University, Milwaukee, Wis., Caroline di Donato, instructor in public health nursing; St. John's University, Brooklyn, N.Y., Philomena Supper, director, Department of Nursing Education; University of Chicago, Chicago, Ill., Eula Butzerin, associate professor of nursing education; University of California, Los Angeles, Calif., Elinor L. Beebe, Ph.D., assistant professor of public health nursing.

The Publications Committee is planning to enlarge its function this year to include a review of needed materials in the public health nursing field—books, textbooks, manuals, and monographs—and also to attempt the placement of articles on various phases of public health nursing in professional health

*Working committee.

and social welfare magazines where interpretation of our field seems to be needed.

The Advisory Committee on Vocational Counseling reported the approval of the public health nursing placement service of the Nursing Bureau of Manhattan and the Bronx, New York, N.Y. Reports from this bureau and the Nurse Placement Service in Chicago were read and accepted.

It was the consensus of this Committee and the Board that more and more need for vocational counseling is developing. The Committee is also watching with interest the growth of professional departments of state employment services. There is an interlocking membership of this Committee and that of the American Nurses' Association concerned with the vocational problems in the general field of nursing.

Edna Hamilton, chairman of the Council of Branches, presented a report of the Council's meeting of the previous day, which will be published in an early issue. On recommendation from the Council, the Montana State Organization for Public Health Nursing was accepted as a branch of the N.O.P.H.N. by the Board and Alice M. West, president of the Montana S.O.P.H.N., responded to this acceptance.

It is hoped that a summary of the first six months' activity of the orthopedic consultant will appear in May. The progress report presented to the Board is therefore not printed at this time.

The Board voted to accept the invitation of the American Public Health Association to hold a dinner meeting of our membership at the annual meeting of the A.P.H.A. in Detroit, Mich., October 7.

Thanks were officially sent to the Russell Sage Foundation for its financial help in revising the *Manual of Public Health Nursing*.

It was voted to ask the N.O.P.H.N.

President to appoint two new committees—one to consider the problem of housing, and the other, safety, with relation to public health nursing.

The request from the American Nurses' Association to consider a study of the three national nursing organizations to determine how they may function in a more uniform way was referred to a committee appointed last April to consider this report. The members of this committee are: Mrs. Frederick S. Dellenbaugh, Jr., Louise Knapp, Ella E. McNeil, Elnora E. Thomson, and Katharine Tucker.

The Committee to Revise the Manual and the Committee on Personnel Policies in Official Agencies were dismissed with thanks, their work being completed.

The N.O.P.H.N. Board approved the suggestion of the American Nurses' Association to appoint a joint committee of the three national nursing organizations to consider the relation of nursing to the National Health Program. The N.O.P.H.N. called attention to the importance of studying the federal plan for the expansion of rural hospital service.

The Board ratified the appointments of Pearl McIver as N.O.P.H.N. representative on the Committee on Accrediting of the National League of Nursing Education; of Alma C. Haupt and Michael M. Davis to serve on the joint committee to work with the National Association of Colored Graduate Nurses; and of Grace Ross and Dorothy Deming (with Ruth Houlton as alternate for Miss Ross) as delegates to the National Social Work Council.

Reports of the White House Conference on Children in a Democracy, and of the meetings of the advisory committees of the United States Children's Bureau were given.

A report of the action of the Joint Board of Directors, which met on January 30, will appear in an early issue.

DOROTHY DEMING

Secretary of the Board of Directors

WITH THE STAFF

Dorothy Deming left New York on February 15 to be away for a month on the West Coast. She was in California from February 20 to March 2 attending regional meetings in Los Angeles, San Diego, Santa Barbara, San Francisco, Fresno, Sacramento, and Redding to discuss with board members and public health nurses some of the problems with relation to the N.O.P.H.N. program of service in the field and the question of West Coast representation on the N.O.P.H.N. Board and committees. From California she went to Oregon and Washington.

Ruth Houlton spent February 21 and 22 in Rochester, N. Y. The first day she spoke at the meeting of the Genesee Valley Nurses' Association, which is District Number 2 of the New York State Nurses' Association. The following day at the meetings of the board and of the staff of the Public Health Nursing Association, she discussed the findings of the health survey in which she participated last October.

On February 13, Evelyn Davis went to Providence, R.I., to speak at the meeting of the S.O.P.H.N. in regard to lay membership. She went to Harrisburg, Pa., on February 16 to conduct the session of agency board members of the institute under the sponsorship of the Harrisburg Welfare Federation. February 28 to March 1, she spent in Oklahoma, conducting discussion meetings in regard to lay committees for public health officers, nurses, and lay people in Ada, Tulsa, and Woodward.

From there she went to Kansas to conduct similar discussion meetings in Wichita, March 4-5 and Kansas City, March 7-8.

Under the sponsorship of the U. S. Children's Bureau, Jessie Stevenson conducted a series of institutes on orthopedic nursing for the Northeastern Regional Orthopedic Conference in New York City from February 8 to 10.

N.O.P.H.N. INCOME AND EXPENSE

1939

Income

Membership dues, individual.....	\$ 30,837.00
Membership dues, agency.....	23,503.70
Contributions	19,090.50
*Magazine	24,111.65
Reimbursements	4,256.03
National Foundation for Infantile Paralysis.....	2,497.32
Miscellaneous	4,703.75

Total income **\$108,999.95**

Expense

Correspondence and consultation \$	29,241.21
Field service.....	21,884.48
Educational service.....	9,692.78
Statistical service and studies.....	11,403.71
*PUBLIC HEALTH NURSING Magazine	
a. Advertising	2,253.00
b. Preparation	6,679.08
c. Printing	7,639.88
d. Subscriptions	8,129.44
Publications and bulletins.....	6,662.19
Community nursing service.....	1,000.00
National Foundation for Infantile Paralysis	2,497.32

Total expense **\$107,083.09**

Summary

Income	\$108,999.95
Expense	107,083.09

Income over expense **\$ 1,916.86**

Life Memberships received for

1939

***PUBLIC HEALTH NURSING Magazine**

Income

Subscriptions	\$19,370.40
Advertising	4,741.25

Total income..... **\$24,111.65**

Expense (allocated)

General administration	\$13,579.36
Travel	220.95
Printing and miscellaneous expense.....	9,998.38
Subscription promotion	902.71

Total expense..... **\$24,701.40**

Summary for magazine

Expense	\$24,701.40
Income	24,111.65

Deficit **\$ 589.75**

HONOR ROLL

With great pride we publish our first Honor Roll list in 1940. We feel sure that there are many more agencies who

have achieved 100 percent enrollment but who have neglected to send us word. If you are one of these, do let us know, so that the name of *your* agency can be on the list published in the next issue and so that we may send you an Honor Roll Certificate as a reward for your loyal support.

We want to make 1940 the best Honor Roll year ever and with your help we can do it!

All public health nursing agencies, including one-nurse services, are eligible for the N.O.P.H.N. Honor Roll. As soon as an agency sends word to the N.O.P.H.N. that all nurses on the staff are 1940 members, an Honor Roll Certificate will be sent and the name of the nursing service will be published in PUBLIC HEALTH NURSING. The name will appear only once, since the list published shows only those nursing services which have achieved 100 percent enrollment since the publication of the previous list.

ALABAMA

- *Metropolitan Life Insurance Nursing Service, Anniston
- Metropolitan Life Insurance Nursing Service, Birmingham
- Bibb County Public Health Nursing Service, Montgomery
- Lee County Health Department, Opelika

ARIZONA

- Miami Public Schools, Miami
- Mothers' Clinic for Planned Parenthood, Tucson
- *Fort Apache Indian Agency, Whiteriver

ARKANSAS

- *Metropolitan Life Insurance Nursing Service, Hot Springs

COLORADO

- Rio Blanco County Health Department, Meeker
- Crowley County Public Health Nursing Service, Ordway

CONNECTICUT

- *Public Health Nursing Department of the United Workers, Norwich

FLORIDA

- Lee County Board of Public Instruction, Fort Myers
- *Seminole County Health Department, Sanford

*Agencies which have been on the Honor Roll for five years or more.

GEORGIA

- Metropolitan Life Insurance Nursing Service, Griffin
- Calhoun County Health Department, Morgan

ILLINOIS

- Freeport Board of Education, Freeport
- Metropolitan Life Insurance Nursing Service, Granite City
- *Ogle County Tuberculosis Sanatorium Board, Oregon

INDIANA

- Crawford County Public Health Nursing Service, English
- *Metropolitan Life Insurance Nursing Service, Kokomo
- Metropolitan Life Insurance Nursing Service, Logansport
- *Public Health Nursing Association, Terre Haute
- Tipton County Public Health Nursing Service, Tipton
- Whiting Chapter, Red Cross Nursing Service, Whiting

IOWA

- Polk County Health Unit, Des Moines
- Johnson County Nursing Service, Iowa City
- Delaware County Nursing Service, Manchester
- District Health Service No. 3, Manchester

KANSAS

- Public Health Nursing Service of Meade County, Meade
- *Public Health Nursing Association, Inc., Topeka

KENTUCKY

- Mercer County Health Department, Harrodsburg
- *Public Health Center, Lexington
- Whitley County Health Department, Williamsburg

LOUISIANA

- Jefferson Chapter Nursing Service, American Red Cross, Gretna
- Jefferson Davis Parish Health Unit, Jennings

MAINE

- The Bangor Anti-Tuberculosis Association, Bangor
- Rockland Visiting Nurse Service, Rockland
- Scarborough Community Nursing Service, Scarborough
- *South Franklin County Nursing Service, Wilton

MARYLAND

- *Metropolitan Life Insurance Nursing Service, Annapolis

MASSACHUSETTS

- Arlington Board of Health, Arlington
- *Visiting Nursing Association of Fitchburg, Fitchburg

District Nursing Association of Barnstable, Yarmouth, and Dennis, Hyannis

*Watertown District Nursing Association, Watertown

MICHIGAN

Dowagiac City Schools, Dowagiac
Ottawa County Health Department, Grand Haven

The Greater Lansing Visiting Nurse Association, Lansing

Metropolitan Life Insurance Nursing Service, Muskegon

*Visiting Nurse Association of Saginaw, Saginaw

MINNESOTA

State Teachers College, Duluth
Martin County Nursing Service, Fairmount

Mankato School Nursing Service, Good Thunder

*Jackson County Nursing Service, Jackson

Division of Public Health Nursing, State Department of Health, Minneapolis
Teachers College, St. Cloud

St. Peter School Nursing Service, St. Peter

MISSOURI

*Metropolitan Life Insurance Nursing Service, Clayton

Cass County Health Unit, Harrisonville
McDonald County Health Unit, Pineville

*The Quaker Oats Company, St. Joseph

*St. Joseph Organization for Public Health Nursing, St. Joseph

*Board of Education, St. Louis

*Municipal Visiting Nurses, St. Louis

MONTANA

Ravalli County Nursing Service, Hamilton

Crippled Children's Division, State Department of Public Welfare, Helena

NEBRASKA

Lincoln and Lancaster County Chapter, American Red Cross, Lincoln

Lincoln and Lancaster County Tuberculosis Association, Lincoln

NEW HAMPSHIRE

*Concord District Nursing Association, Concord

NEW JERSEY

Dunellen Board of Education, Dunellen

*New Jersey State Department of Public Instruction, Trenton

NEW MEXICO

Lindvith Health Center, Regina

NEW YORK

*Metropolitan Life Insurance Nursing Service, Batavia

Metropolitan Life Insurance Nursing Service, Endicott

*Metropolitan Eastern Long Island Nursing Service, Hempstead

Metropolitan Life Insurance Nursing Service, Kingston

Metropolitan Life Insurance Nursing Service, Lancaster

Judson Health Center, New York

*National Organization for Public Health Nursing, New York

Metropolitan Life Insurance Nursing Service, Oneida

*Metropolitan Life Insurance Nursing Service, Port Jervis

Metropolitan Life Insurance Nursing Service, Poughkeepsie

NORTH CAROLINA

Metropolitan Life Insurance Nursing Service, Durham

Greene County Health Department, Snow Hill

NORTH DAKOTA

State Health Department, Bismarck

OHIO

*Metropolitan Life Insurance Nursing Service, Akron

*American Red Cross Public Health Nursing Service, East Liverpool

*Public Health Nursing Department, Massillon City Hospital

Metropolitan Life Insurance Nursing Service, Middletown

*Metropolitan Life Insurance Nursing Service, Steubenville

OKLAHOMA

*Cleveland County Health Unit, Moore

*Norman Public School, Norman

*Metropolitan Life Insurance Nursing Service, Oklahoma City

Seminole County Health Department, Seminole

Seminole County Health Department, Wewoka

PENNSYLVANIA

Millersburg Community Nursing Association, Millersburg

American Red Cross, Montrose Chapter, Montrose

Visiting Nurse Society of Philadelphia, Philadelphia

Visiting Nurse Society of Pottstown, Pottstown

*Visiting Nurse Association, Reading

American Red Cross, Public Health Nursing Service, Vandergrift

RHODE ISLAND

Warwick District Nursing Association, Apponaug

*Burrillville District Nursing Association, Pascoag

SOUTH DAKOTA

Stanley County Public Health Service, Fort Pierre

TENNESSEE

*Metropolitan Life Insurance Nursing Service, Nashville

*Agencies which have been on the Honor Roll for five years or more.

Gibson County Department of Public Health, Trenton

VIRGINIA

Metropolitan Life Insurance Nursing Service, Petersburg

*Metropolitan Life Insurance Nursing Service, Portsmouth

WEST VIRGINIA

Metropolitan Life Insurance Nursing Service, Bluefield

Public Health Training Center, Morgantown

WISCONSIN

Metropolitan Life Insurance Nursing Service, Fond du Lac

Marinette County Health Service, Marinette

*Visiting Nurse Association, Neenah
Clark County Public Health Nursing Service, Neillsville

*Marathon County Health Department, Wausau

HAWAII

*Palama Settlement, Honolulu



TENTATIVE BIENNIAL CONVENTION PROGRAMS

PHILADELPHIA, PENNSYLVANIA, MAY 12-18

JOINT SESSIONS

All Joint General Sessions will be held in the Convention Hall.

Monday, May 13: Opening Session, 8:15 p.m.

Presiding—Julia C. Stimson, President, American Nurses' Association

Invocation—Rev. William B. Stimson, St. Mary's Church, West Philadelphia, Pa.

Welcome to Philadelphia—Speaker to be announced

Greetings from the state—Speaker to be announced

Response to address of welcome—Nellie X. Hawkinson, President, National League of Nursing Education

Address: The Contribution of the Professions in a Democracy—Mildred Fairchild, Ph.D., Director, Carola Woerishoffer Graduate Department of Social Economy and Social Research, Bryn Mawr College, Bryn Mawr, Pa.

Historical Pageant

Wednesday, May 15: 9:00 a.m.

Presiding—Grace Ross, President, National Organization for Public Health Nursing
Report of Joint Committee on Community Nursing Service—Mrs. Elsbeth H. Vaughan, Chairman

Report of Joint Committee to Outline Prin-

ciples and Policies for the Control of Subsidiary Workers in the Care of the Sick—Ella Hasenjaeger, Chairman

Thursday, May 16: 9:00 a.m.

Presiding—Nellie X. Hawkinson, President, National League of Nursing Education

Symposium: Preparation of the Nurse for Leadership in a Democracy

Chairman: Arthur J. Jones, Ph.D., Department of Social Education, University of Pennsylvania

Address: Character Education—Speaker to be announced

Address: Civic Education—Mrs. Curtis Bok, Lecturer

Address: Nursing Education—Marion Howell, M.Sc., Dean, Frances Payne Bolton School of Nursing, Western Reserve University, Cleveland, Ohio

Address: Professional Guidance for Leadership—Althea H. Kratz, Directress of Women, University of Pennsylvania, Philadelphia, Pennsylvania

Thursday, May 16: 8:30 p.m.

Presiding—Mary Beard, Director, Nursing Service, American Red Cross

Invocation

Red Cross Session—Speakers to be announced

N.O.P.H.N. PROGRAM

*Saturday and Sunday: Group Conferences***Monday, May 13, 9:00-10:30 a.m.*

General Registration

10:45-12:00 a.m.

N.O.P.H.N. Board of Directors (closed meeting)

1:00-2:30 p.m.—Luncheon: N.O.P.H.N. Sponsored by Industrial Nursing Section

2:30-4:00 p.m.

Round Tables

Industrial Nursing

Rural Home Delivery Problems

Merit System (its philosophy and application)

4:30-6:00 p.m.—Special Round Table

Tuesday, May 14: 9:00-10:30 a.m.

N.O.P.H.N. General Session—Working Together in the Community

10:45-12:00 a.m.

N.O.P.H.N. Business Meeting (open only to N.O.P.H.N. members, by membership card)

1:00-2:30 p.m.—Luncheon: N.O.P.H.N. Membership Rally

2:30-4:00 p.m.

Round Tables

Earnings in Public Health Nursing Agencies

*See PUBLIC HEALTH NURSING, January 1940, page 57.

The Nurse in Her Community Relationships

4:30-6:00 p.m.

Special Round Tables

Board Members' Tea

8:00 p.m.—Dinner: N.O.P.H.N. Council of Branches

Wednesday, May 15: 10:45-12:00 a.m.

N.O.P.H.N. General Session—Nutrition

1:00-2:30 p.m.—Luncheon: N.O.P.H.N. School Nursing Section

Business Session

2:30 p.m.—Sightseeing

7:00 p.m.—Dinner: N.O.P.H.N. (sponsored by Board and Committee Members' Section)

Thursday, May 16: 2:30-4:00 p.m.

Round Tables

Problems of Student Affiliation*

Radio Publicity

4:30-6:00 p.m.—Special Round Tables

Friday, May 17: 9:00-10:30 a.m.

N.O.P.H.N. General Session—Leadership in Supervision

10:45-12:00 a.m.

N.O.P.H.N. Business Session (open only to N.O.P.H.N. members by membership card)

*In conjunction with the National League of Nursing Education.

Special round tables are planned for the late afternoons in the period from 4:30 to 6:00 p.m. They are as follows: Monday—board members; Tuesday—mother's milk bureaus, costs in public health nursing agencies, camp nursing; Thursday—supervisors of school nursing, college nursing, board members.

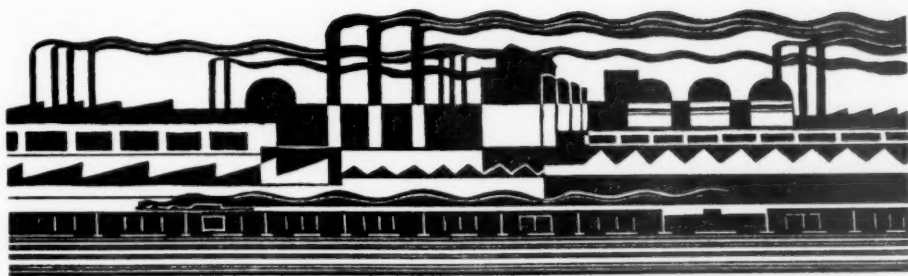
A tea for the board members attending the Biennial Convention will be held on Tuesday, May 14, the hostesses to be the members of the Board of Directors of the Visiting Nurse Society of Philadelphia.

A more complete N.O.P.H.N. program will be published in the April number of PUBLIC HEALTH NURSING.

RESERVATIONS AT THE BIENNIAL

Those expecting to attend the Biennial Convention in Philadelphia, May 12 to 18, are urged to make their hotel reservations promptly. Attention is called to the list of hotels and rates in the December 1939 issue, page 711, and also the

map of central Philadelphia in the October issue, page 582. The chairman of the Committee on Housing, Sarah Krewson, 2350 East Sergeant Street, Philadelphia, Pa., will be glad to assist with any housing problems.



Health of Workers in a Sugar Refinery

The work of this industrial health service includes pre-employment and annual examinations, control of syphilis and other communicable diseases, and health education

THE MEDICAL department of the Savannah Sugar Refinery deals with the examination of new employees who must be placed in positions commensurate with their physical condition, with the handling of accidents promptly and adequately, with safety precautions, and with the prevention and treatment of disease. The refinery is located on the Savannah River about six miles north of the city of Savannah, Georgia. Approximately six hundred and fifty people are employed by the company.

A part of the site immediately adjoining the plant has been developed by the refinery into a village for many of its employees. The village consists of fifty houses and apartments for the white employees, and forty houses for Negro employees, the latter being located just beyond the white village. The company also maintains a hotel for those employees who have no families. The buildings are of modern construction, with all of the facilities necessary for comfort and convenience. The houses are steam-heated and supplied with electricity for lighting and cooking purposes. The company also maintains a corps of gardeners who keep the gardens sur-

rounding the houses and the entire site of the plant thoroughly planted and clean. Shade is provided by large live oak trees. There is also a recreational park, containing a baseball diamond, and basketball and tennis courts. Provision is made in the hotel for community meetings, parties, dances, and classes for adults. There are also meeting rooms for boy scout and girl scout troops.

The objective of an industrial establishment is the production and distribution of goods with the least possible impairment of efficiency, and the maintenance of health in the plant personnel is of utmost importance to full-time production. To each worker, too, every hour is a matter of dollars and cents. An organization which is to have satisfied employees must consider the human element.

The medical department was started at the opening of the plant in 1917, with a physician on full-time service, and the health service has always been a vital factor in the development of good rapport between the employer and employees. In September 1934, an industrial nurse was employed. Satisfactory offices were furnished and new equipment sufficient to do all but major surgery was obtained. Autoclaves, sterilizers, and essential supplies were provided. In 1935 a new program was started.

HEALTH EXAMINATIONS

Examinations are given each applicant for a permanent position. This includes the examination of the eyes, ears, nose, throat, heart, lungs, abdomen, and extremities, a Wassermann test, and urinalysis. The applicant is notified if there are any defects and his application is held up until they are corrected. If he is accepted, the applicant is placed in a position commensurate with his physical condition. Each employee has a yearly health examination similar to his pre-employment examination. If the worker is absent from work for an appreciable time, a medical slip verifying his ability to work must be obtained from the plant physician before he is allowed to return.

A card index is used and a complete record of the visits of employees to the medical department is kept. Every minor as well as major injury is reported and details are obtained. After each visit for treatment of an injury the employee must have a note from the medical department to the foreman in order to return to work. The date on which the patient is to return for treatment is noted on the slip.

Accidents have decreased greatly as a result of safety-first campaigns. There is an inspection of the plant at intervals and after each accident. A meeting of the medical department staff and the safety-first committee is held once a month, at which time accident prevention and means of protecting workers against recurrence of injuries are discussed. Posters are used for safety education.

Each injured employee is required to report to the medical department, no matter how trivial the accident. Prompt attention has practically obviated infections following injuries, and none has occurred in the past five years. The injured employee either returns to work after first-aid treatment or is sent home if he cannot work and hospitalization is not necessary. Every effort is made to

return the patient to work as soon as possible. If he is unable to assume his regular duties, he is assigned to lighter or more suitable work.

The laboratory was started in 1935, when necessary equipment was obtained to do the routine tests including urinalysis, examination of smears, and blood tests. Many of these are done by the nurse under the direction of the physician. The microscopic work is of inestimable value in establishing early diagnosis and it alone has saved the employer more than enough to equip the laboratory.

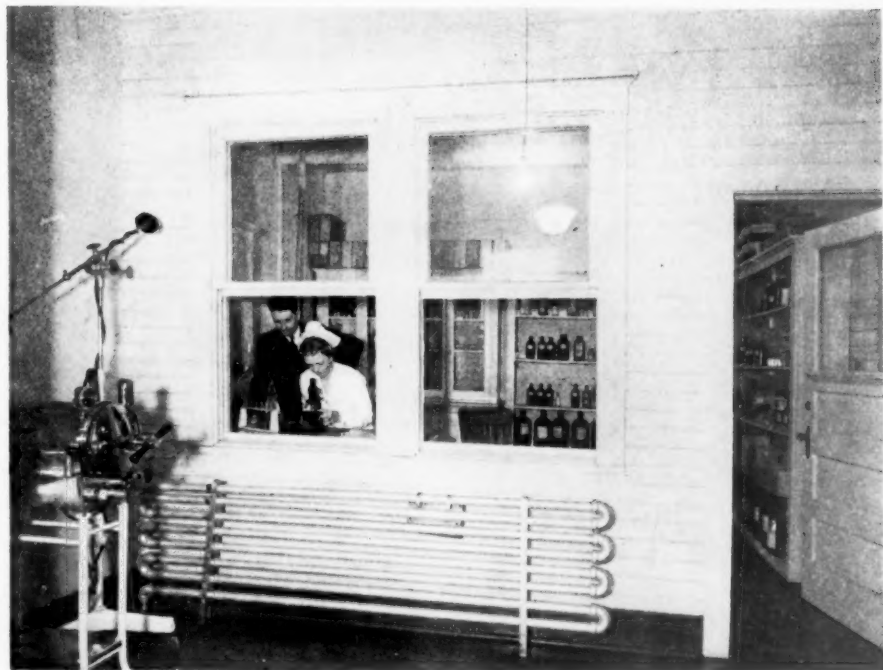
MALARIA PREVENTION

In the spring of 1936 there was an epidemic of malaria in the vicinity of the plant. A total of 109 cases were found to be positive and the patients were given atabrine, plasmochin, and quinine. Coöperation was obtained from the county officials, and good drainage was established. Proper screening of homes was advocated. In the spring of 1937 all employees who had had malaria in 1936 were given a prophylactic treatment of atabrine and plasmochin. A marked reduction in the number of cases occurred. Only 18 patients were treated in that year, and 6 in 1939.

It was not until the summer of 1937 that a program for the control of typhoid fever was organized. Vaccine was obtained and offered to all employees and their families. The response was excellent and the greater portion of workers and families took advantage of the opportunity.

Due to the efforts of the local health department, most children of school age have received diphtheria immunization. Early in 1936 a campaign was organized and all children in the vicinity of the plant were given toxoid. Now each child receives toxoid when he is six months of age. Diphtheria has been kept at a minimum.

Some employees who were susceptible



The staff who safeguard the health of the plant

to colds were given oral cold vaccine in 1937 with favorable results. In the fall of 1938 the administration of the vaccine was begun as routine and has been continued. There is evidence that marked benefit has resulted.

SYPHILIS CONTROL

The control of syphilis and gonorrhea was undertaken in 1935 and since the emphasis on these diseases by the United States Public Health Service, great advances have been made. A supply of the Public Health Service pamphlet, *Syphilis—Its Cause—Its Spread—Its Cure*, was secured and a copy given to each employee. Employees coming to the department for dressings were encouraged to talk about the disease, and by this means considerable interest was aroused. The fact that the superintendent called a meeting of all department heads to urge their definite cooperation in the drive had much to do with its success.

A clinic is maintained where employees, whose Wassermann tests prove positive, receive treatment. The plant drive on syphilis has been a worth-while project and the good accomplished has more than warranted the expense incurred. Routine blood tests and the treatment of syphilis are now permanently established.

HEAT CRAMPS DECREASED

Records of the number of cases of heat cramps and prostration are not available previous to 1935, but following the lead of the medical service of the Bethlehem Steel Company, sodium chloride tablets were placed in dispensers at each drinking fountain and water cooler throughout the plant. Directions for use were written on each dispenser. With the processes in the manufacture of sugar there are certain stations where the temperatures are rather high and a great deal of time was lost by employees prior to the use of salt. Since 1935 no

employee has lost time, although a few heat cramps were experienced. In the beginning, there was a meeting of plant foremen, where the use of the tablets was explained and they were asked to encourage their employees to take the tablets. Each employee visiting the medical department was told about their use. Their value was doubted by some at first but at the present time the general consensus is that the workers stand the heat better and feel better.

An opportunity is afforded to learn something about the health habits, diet, recreation, and minor disorders of employees as they come to the office for health examinations and dressings of injuries. Instruction is given by the physician and nurse in regard to the correction of faulty habits of hygiene and the prevention of disease.

Classes on home hygiene and care of the sick are given by the plant nurse to the mothers in the vicinity, under the auspices of the American Red Cross. It is believed that the instruction of employees and their families in the care of themselves will aid materially in safeguarding the general health of the employees and the community.

Classes in first aid are also given to all employees and families under the auspices of the Red Cross.

Although the health program is far from complete it is at least established on a firm basis, and material benefit has been noted in the diminished loss of time from work, the decrease in accidents, and the improvement in health.

FRIEDA M. GREFE, R.N.

*Savannah Sugar Refinery
Savannah, Georgia*

EMOTIONAL CAUSES OF ACCIDENTS

EMOTIONAL maladjustments as a cause of accidents are discussed in an article by Dr. Lydia G. Giberson, industrial psychiatrist of the Metropolitan Life Insurance Company, in *National Safety News* for February 1940. ("Emotional First Aid," page 10.)

"For years," says Dr. Giberson, "I have observed the emotional maladjustments of employees and it is my experience and my judgment that the majority of accidents have their sources in the human factors. I have come to be-

lieve that an accident is a telltale symptom of emotional illness."

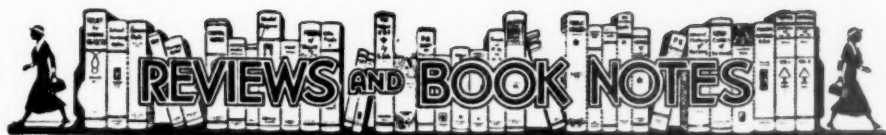
"Causes deep in the private life of the worker may bring about in their logical sequence accidents which are completely unexplainable on the surface."

Dr. Giberson specifies two basic requirements for an accident: lack of physical coordination and lack of attention. Her discussion of the physical and psychological causes behind these factors and her suggestions for preventing them comprise an article which no industrial nurse can afford to miss.

INDUSTRIAL HYGIENE CONFERENCE AT THE BIENNIAL

The conference on industrial hygiene at the Biennial Convention will be conducted by J. J. Bloomfield, sanitary engineer, Division of Industrial Hygiene, U. S. Public Health Service, and Dr. E. G. Meiter, director, Industrial Hygiene Laboratory, Employers Mutuals. There will be *no registration fee* for this institute. (This is a correction of the

announcement in PUBLIC HEALTH NURSING, January issue, page 57.) The conference is open to 60 nurses, who will be accepted in the order of their appointment. Registrations should reach the N.O.P.H.N., Room 836, 50 West 50 Street, New York, N. Y., before April 15. Notification of acceptance will be sent.



MANUAL OF PUBLIC HEALTH NURSING

Prepared by the National Organization for Public Health Nursing. 529 pp. The Macmillan Company, New York, third edition revised and reset, 1939. \$2.50.

The field of public health nursing grows increasingly complex and hence the revised and additional content of the third edition of the *Manual of Public Health Nursing* is timely and helpful.

The aim of the revised manual, as stated in the Foreword, is to present underlying principles which may be applied *with modification* to the various areas of service. It is *not intended* as a pattern to be adopted *in toto* by every community. It would appear that for the most part, this aim has been attained in the preparation of the manual because much of the content has to do with the broader aspects of administration. However, considerable space has been given, also, to the discussion of specific nursing procedures and techniques which may be found in any good book on practical nursing procedures, and with which every graduate nurse should be familiar.

Most noteworthy are the excellent chapters on relationships, program-planning, preparation of the public health nurse, and records and reports. Certain of these topics might merit even greater elaboration. All too frequently when directors of public health nursing services and staff nurses themselves are questioned regarding shortages in public health nursing preparation they mention lack of working knowledge of community organizations, inability to plan public health nursing programs, and lack of interest in records and reports.

The selected references appearing at the end of the chapters in Part III, Services to the Family, should prove

helpful in supplementing information on the various public health nursing activities. With regard to the organization and presentation of the content of Part III, it is believed that a separate chapter should be devoted to communicable disease control rather than grouping this major activity under Morbidity Nursing Service, in recognition that the preventive aspects of communicable diseases constitute a major factor in the control program. Might not the chapter heading Morbidity Nursing Service be dispensed with entirely, and the curative as well as the preventive aspects pertinent to the respective services be discussed in conjunction with each major service?

Likewise, might it not be well to delete the section on Nursing Procedures, which deals with special treatments, since this phase of basic nursing will be modified by the respective official and nonofficial agencies to meet their varying needs?

Public health administrators and all public health nurses should find this recently revised manual of public health nursing very helpful and it might well serve as a text in planning programs for staff conferences.

MARY J. DUNN, R.N.

Public Health Nursing Consultant
U. S. Public Health Service

PULMONARY TUBERCULOSIS

By Jacob Segal, M.D. 150 pp. Oxford University Press, New York, 1939. \$2.75.

This volume, which is written primarily for the practitioner, the health officer, and the medical student, should provide an excellent reference book for the nurse. The author has endeavored to condense the subject of tuberculosis into one hundred fifty pages including

twenty-one illustrations of chest roentgenograms. The discussions comprise the most modern concepts on the definition of the disease, modes of transmission, pathogenesis, pathology, clinical types, symptomatology, complications, methods of diagnosis and treatment, and prevention.

Dr. Segal stresses psychotherapy as an important adjunct to treatment. He also emphasizes the fact that follow-up instruction should be entrusted to well qualified persons only.

This book would be a valuable addition to the library of the public health nurse.

GOLDA B. SLIEF, R.N.
Oklahoma City, Oklahoma

HEALTH AT FIFTY

Edited by William H. Robey. 299 pp. Harvard University Press, Cambridge, Mass., 1939. \$3.

This book comprises twelve of the most popular of a series of free lectures given in Boston during the last few years by the faculty of the Harvard Medical School to make "available to the public the current knowledge of the causation, treatment, and prevention of disease."

The topics selected deal with the problems that arise with increasing age. But we are warned not to be misled by the title, for health at fifty and beyond implies "conservation and promotion of physical and mental vigor during childhood and adolescence."

A chapter each is devoted to such subjects as heart disease, blood pressure, overweight, cancer, rheumatism, normal and abnormal menstruation, the menopause, care of the eyes, and vitamins. Throughout, emphasis is placed upon the preventive aspects, with sufficient knowledge of the disease itself to lead to prompt recognition of danger signals as well as to relieve undue apprehension over conditions of minor importance.

The book emphasizes the enormous number of people afflicted with these

diseases of later life, to which, until recently, so little attention has been given, and on which so little money has been spent.

There are repeated warnings to seek skilled medical advice and to avoid the use of home remedies and patent medicines. "While diagnosis and treatment are occasionally simple, they are more often problems beyond the scope of a layman plus a book." One entire chapter dealing with The Family Medicine Cabinet contains a humorous description of the contents of the writer's own cabinet, and suggestions for a simple list of contents.

The book is written for the laity, and for the most part it is expressed in simple language. However, the detail in some of the chapters—such as the discussion on menstruation and care of the eyes—is quite technical for the average lay reader.

The final chapter, Preparing for a Comfortable Old Age, is a fitting summary "whereby the lengthened years may be faced with some degree of assurance that 'the best is yet to be.'" E.L.P.

HEALTH FOR THE MILLIONS

Health for 7,500,000 People. Annual Report of the Department of Health, City of New York for 1937 and a Review of Developments from 1934 to 1938. 390 pp. Department of Health, 125 Worth Street, New York, 1939.

Health for New York City's Millions. An Account of Activities of the Department of Health of the City of New York for 1938 with Comparative Vital Statistics Tables. 295 pp. Department of Health, 125 Worth Street, New York, 1939.

In these reports the importance of public health nursing in the program of the New York City Department of Health is indicated by the fact that out of a budget of over \$4,700,000, \$1,500,000 is allocated to nursing. In 1937 there were 797 civil service nurses on the staff and in 1938 their number increased to 850.

The trend from specialized to generalized nursing is indicated in both reports. A summary of the progress toward generalization in five years is

presented in the 1937 report. However, in 1938 it is reported that of the thirty health center districts only eleven had been able as yet to achieve generalization of the service. A continuous staff education program aims to further this development.

Those interested in public health nursing will find much to interest them in other sections of these reports. They are extremely well prepared and interestingly written, with clear photographs and charts. There is, however, a need for nursing supervision of photographs which depict nursing activities. Pictures should always present the most desirable type of technique. In one picture of a home call a nurse is sitting on a bed with the mother and children gathered about her. Those who see the value of a public health nursing uniform will miss the neatness and trimness of

such a uniform in the pictures which present the nurses in street clothes. In the clinic pictures, the nurse is presented dressed in white, wearing a cap—a uniform which one usually associates with the hospital.

It is interesting to find in the 1938 report a section devoted to the Advisory Committee on Nursing. Although it is not new, this committee is reported to have materially strengthened its own organization. It has its own constitution and bylaws; it has subcommittees on tuberculosis, social hygiene, and acute communicable disease. The members make observation visits and the committee has issued and recently revised a popular leaflet, *What the Public Health Nurse Does for You*, of which 12,000 copies were distributed.

ELEANOR W. MUMFORD, R.N.
New York, New York

RECENT PUBLICATIONS AND CURRENT PERIODICALS

NUTRITION

QUANTITY RECIPES FOR QUALITY FOODS. Evaporated Milk Association, 307 North Michigan Avenue, Chicago, 1939. 63 pp. Free.
198 low-cost recipes for 50 or more servings.

NUTRITION AND PHYSICAL FITNESS. L. Jean Bogert, Ph.D. W. B. Saunders Company, Philadelphia, third edition, 1939. 602 pp. \$3.

THE THERAPEUTIC USE OF SYNTHETIC VITAMINS. Editorial *New England Journal of Medicine*, September 21, 1939, p. 475.

This article discusses limitations of the use of synthetic vitamins.

TEACHING NUTRITION IN BIOLOGY CLASSES: AN EXPERIMENTAL INVESTIGATION OF HIGH SCHOOL BIOLOGY PUPILS IN THEIR STUDY OF THE RELATION OF FOOD TO PHYSICAL WELL-BEING. N. Eldred Bingham, Ph.D. Bureau of Publications, Teachers College, Columbia University, New York, 1939. 117 pp. \$1.85.

DIETS OF FAMILIES OF EMPLOYED WAGE EARNERS AND CLERICAL WORKERS IN CITIES. Hazel K. Stiebeling and Esther F. Phipard. Circular 507, United States Department of

Agriculture. 141 pp. Obtainable from Superintendent of Documents, Washington, D.C. 15c.

Report of a study showing what foods typical American city families eat and how their diet compares with nutritional standards. Diets could be improved without much additional expense by placing more emphasis on leafy and green-colored vegetables and upon milk.

SURVEY OF NATIONAL NUTRITION POLICIES 1937-1938. Series of League of Nations Publications, II Economic and Financial, 1938, II A, 25. 120 pp. Columbia University Press, New York, 1939. 60c.

A summary of reports on the state of nutrition in various countries.

FOOD VALUES OF PORTIONS COMMONLY USED. Anna de Planter Bowes and Charles F. Church, M.D. Philadelphia Child Health Society, 311 South Juniper Street, Philadelphia, 1939. \$1.

Second edition of handbook completely rewritten and enlarged by Mrs. Bowes, showing nutritional values of common foods. Good reference material for public health nurses.



- The Joint Committee on Health Problems in Education of the National Education Association of the United States and the American Medical Association has arranged a symposium on "How can education improve the nation's health" during the meeting of the American Association of School Administrators. It will take place on February 28 at 2 p.m. in the Auditorium of Bishop Tuttle Memorial Hall, St. Louis, Mo.

- A three-day institute for administrators, teachers, and supervisors in nursing will be held June 20-22 at The University of Chicago, Judson Court, 1005 East 60 Street, Chicago, Ill. The central theme of the institute will be "Tests and measurements in the improvement of instruction." Copies of the program may be secured in April.

The requirements for admission to the Department of Nursing Education will not apply in the case of those who wish to register for the institute. Registration will be limited and reservations will be accepted in the order of application. Application for registration may be made by writing to Nellie X. Hawkinson, Department of Nursing Education, The University of Chicago. A registration fee of \$3 will be charged.

Room and board will be provided in Judson Court for the period of the institute for \$8.50. Reservations may be made through William J. Mather, bursar, The University of Chicago.

- This year dentistry celebrates its hundredth anniversary. The charter for the first dental school in the world was granted by the State of Maryland to the

Baltimore College of Dental Surgery on February 1, 1840. The American Society of Dental Surgeons, the first national dental organization, was founded on August 18, 1840. During the previous year, 1839, the first national dental journal, *The American Journal of Dental Science* (now *The Journal of the American Dental Association*), was published in this country. That year marked the beginning of the transformation of dentistry from a craft to a profession. American dentistry has developed now to the place where it is recognized as the best in the world.

The American Society of Dental Surgeons has been succeeded by the American Dental Association with a membership of over two thirds of the 62,000 practicing dentists in the United States. On March 11, more than 400 component societies of this organization in every state in the Union will hold centennial dinners commemorating dentistry's hundredth anniversary as a profession. From March 18-20 a national dental centenary celebration will be observed in Baltimore, Md., the site of the first dental school, and the home of the first dental journal and the first national dental organization.

- The medical and public health exhibits at the New York World's Fair will be reopened for the 1940 season beginning May 11. These exhibits were attended by 7,500,000 visitors in 1939, or one third of the total attendance at the Fair. New exhibits will be added to the Carrel-Lindbergh "heart," the transparent man, and other dramatizations of medical science.

- Boys and Girls Week will be observed from April 27 to May 4. Its purpose is to focus the attention of the community upon boys and girls—their problems, activities, and training—and to enlist the cooperation of all agencies and individuals in a year-round program for the health, safety, and optimal development of the coming generation. Information in regard to the program may be obtained from the National Boys and Girls Week Committee, Room 950, 35 East Wacker Drive, Chicago, Ill.

- The Isabel Hampton Robb Memorial Fund is celebrating its twenty-ninth birthday anniversary. Soon after Mrs. Robb's death in 1910, this fund was established as a memorial to her. Its purpose is to grant scholarships to prepare graduate nurses for executive or teaching positions. The committee to administer this fund consists of fifteen members, five from each national organization, though the actual work is done by an executive committee of five, chosen from these members. The first scholarships were awarded in 1912 to graduates from two Chicago schools of nursing. The fund now comprises \$31,000.

The purposes of this anniversary celebration are to renew interest in the increasing need for educational opportunity for nurses and to attain the original goal of \$50,000. Contributions to the fund—which should be made payable to the Isabel Hampton Robb Memorial Fund—may be sent to Mrs. Mary C. Eden, The Fairfax, 43 and Locust Streets, Philadelphia, Pa.

- The New Jersey State Organization for Public Health Nursing is planning a special program at its annual meeting this year on the occasion of its twenty-fifth anniversary. The meeting will be held at the Berkley-Carteret Hotel, Asbury Park, N.J., April 19. Dorothy Deming, general director of the National Organization for Public Health Nursing, will bring greetings from the N.O.P.H.N.

- The objective of the National Negro Health Week, March 31 to April 7, is "coöperative endeavor for the attainment of community health." Copies of the National Negro Health Week bulletin, poster, and school leaflet may be obtained from the National Negro Health Week Committee, U. S. Public Health Service, Washington, D.C., without cost for limited quantities.

- South Carolina is the second state in the Union to add birth control to its public health program, North Carolina being the pioneer state in this field. The service is available to every married woman in the state who presents a medical certificate by a licensed physician that she is in need of it and who is not able to pay for it. A qualified public health nurse with experience in welfare work in a southern community is to be employed as "consultant nurse in pregnancy spacing" under the auspices of the State Board of Health, the project to be financed by the Birth Control Federation of America. She will be lent to county health departments and county and district medical societies to assist in the organization of local services. The plan was submitted to the State Board of Health by the South Carolina Medical Association and has the Association's full coöperation.

- As a tribute to the memory of Ella Phillips Crandall, first executive secretary of the National Organization for Public Health Nursing, who died last year, her friends wish to contribute toward the building of a room in the new wing of single rooms to be added to Nurses House, Babylon, Long Island, N.Y. The sum of \$1500 will build one room; \$300 will furnish it; and another \$1500 will endow it. Many contributions ranging from \$1 to \$100 have already been received. Nurses who would like to participate in this gift may send contributions to Anne A. Stevens, Sunset, Germantown, N. Y., before March 10.

Our Readers Say . . .

THIS COLUMN is intended to serve as a forum for the expression of reader opinion. Only signed letters will be published, although the signature will not be used except with the writer's permission. The National Organization for Public Health Nursing is not responsible for opinions expressed on this page.

EXPERT HELP IN PUBLICITY

Voluntarily specialized ability in the publicity field can give valuable aid to public health nursing organizations in interpreting their work. The Public Health Nursing Association in Des Moines, Iowa, has had the advantage of some good publicity during the past year through a project that was carried on by the Des Moines Advertising Club. The following letter from the person assigned to the Association came in answer to a request that he give us a picture of the program he was carrying on for the Association:

E. K. D.

I was asked by the chairman of the publicity committee of the Des Moines Advertising Club, which assists with the Community Chest drive each year, to select an agency which I was willing to serve during the year as a consultant in the field of advertising and promotion. I chose the Public Health Nursing Association because I knew it was rendering a highly important service which was little known by the citizens of Des Moines. It was understood that whatever work I was able to do would be supplementary to the work already being very well done by the Community Chest office, working with an inadequate force. Actually we did a comparatively few things, but I believe each of them served to call very definitely to the attention of Des Moines citizens the wonderful service of the Public Health Nursing Association.

Two dramatized radio programs were presented by our school of radio. Drake University students wrote the continuity and presented the programs on local radio stations, which were glad to give free time to the enterprise. We prepared a half dozen letters reporting specifically as to the service accomplished by the nurses, asked local citizens to sign them, and sent them to the editor of the local newspaper who was glad to print each of them. One of the letters gave the names of the women of the local board and expressed

public appreciation of their work. We were also able to place a few additional feature stories in the newspapers, illustrating the work of the Nursing Association.

You see, therefore, that the service was not a particularly difficult one and required a comparatively few hours of time. Our local women did appreciate it, however, and felt that great good was accomplished.

I have been assigned this year for similar service with the local Girl Scouts organization, but have continued to send in letters about the work of the Nursing Association which I have prepared from the monthly reports.

E. C. LYTTON

*Business Manager
Drake University
Des Moines, Iowa*

AN INDUSTRIAL NURSE WRITES

The articles in the magazine every month are so very interesting, I look forward to them. I am employed by the Nashua Manufacturing Company, which manufactures blankets, flannels, table felt, sheets, and specialties.

There are three thousand employees, some departments working three shifts. We have two nurses, one for the first shift and one for the second, so that we are available to administer emergency care, dressings, and lamp treatments to workers during the entire period of the day shifts.

We have five doctors on the panel, available at all times. More serious cases are sent directly to the hospital, the doctor having been notified in advance. There are medical standing orders to guide the nurse in her work.

Having done public health nursing here in Nashua for five years, I come in contact with many employees in whose homes I visited in the district.

BERNICE LADD, R.N.

*Industrial Nurse
Nashua, N. H.*

PUBLIC HEALTH NURSING

Official Organ of the National Organization for Public Health Nursing, Inc.

A New Use for Familiar Tools

JOB classification, examinations, compensation plans, promotions, personnel systems, service ratings, staff development—all these have a familiar ring to public health nurses.

Job classification reminds us of our old friend "minimum qualifications" which the National Organization for Public Health Nursing with the help of the American Public Health Association introduced to the world of public health nursing in 1925. Classes of positions were established, qualifications were set up, and later, duties and functions were added in each classification. These have been used generally for guidance in the selection of public health nurses in all types of agencies. Now they have become the basis for the more refined job definitions for public health nursing personnel in the recommended standards adopted by the United States Children's Bureau for the guidance of state agencies in setting up merit system plans.

The oral examination is the familiar personal interview adapted to the more complicated problems of personnel selection presented in agencies supported by tax funds; it supplements the written tests and the ratings of training and experience.

Personnel policies for public health nursing services have been studied and definite recommendations made in the *Board Members' Manual*,* which was first published in 1930, and later in the

Personnel Policies in Public Health Nursing by Marion G. Randall, in 1937. Studies to guide the determination of salary schedules for the various job classes, principles upon which to base promotions, and policies for sick leave, vacations, and the like have appeared frequently as recommendations in publications of the N.O.P.H.N.

Efficiency reports, activity records, rating sheets, and other schemes for evaluation have been quite generally used in public health nursing services for helping the individual to develop her possibilities. With refinement and standardization, such tools may become the record necessary for a service rating plan in the merit system administration.

Staff development through an in-service training program! Readers will remember the conclusion of the survey of public health nursing made in 1934 that adequate provision for supervision and staff education were important factors making for better performance of the nurse. Now, Mr. Albert H. Aronson tells us that in-service education is necessary if a merit system is to succeed.

Mr. Aronson's article on "The Merit System" in the March issue, and Marion W. Sheahan's article on page 248 of this issue introduce a series of discussions on this subject to appear in **PUBLIC HEALTH NURSING**. Both of these writers emphasize the necessity for professional participation in the administration of the merit system if it is to succeed. This responsibility in public health nursing will fall largely upon state and local nursing groups.

Public health nurses have for many

*National Organization for Public Health Nursing. *Board Members' Manual*. The Macmillan Company, New York, second edition revised and reset, 1937.

years accepted and made use of most of the principles and techniques involved in the merit system. Now, they must prepare themselves to apply these same principles and techniques to larger, more competitive groups under an organized

system of governmental control. With tools already sharpened by use, the same spirit which has been so successful in smaller groups can be retained under the more formal plan of the merit system.

V. J.

HAZARD OF LEAD NIPPLE SHIELDS

THE GRAVE hazard to a nursing infant from the use of lead nipple shields is emphasized in a report by two New York physicians in *The Journal of Pediatrics* for November 1939.* The authors describe a fatal case of lead poisoning in a four-months-old infant following prolonged use of lead nipple shields by the mother. A week after nursing had been discontinued, a specimen of breast milk was found to contain a large amount of lead.

The authors also collected reports of six other cases of lead poisoning due to nipple shields, of which two are described.

They call attention to the fact that "the lead nipple shield is commonly employed and highly recommended in the treatment of fissured nipples. It can be purchased at almost any drug store. The descriptive matter accompanying these shields states that they have been used since 1842 and that 'they are in no way likely to be injurious to the infant.'"

Although in the cases reported, the nipple shields were used for several months, the writers express the opinion that "there are undoubtedly many infants who must absorb toxic amounts of lead even when the shields are used for only a short period of time." They believe that: "The rarity of frank cases

of intoxication may be due to the fact that there is a well known personal variation of susceptibility to lead, as well as the fact that most mothers stop using the shields after a few weeks."

Recently the New York State Department of Health issued a regulation to take effect February 1, 1940, prohibiting "the sale or use of metal or foil breast nipple shields made of or containing lead." A survey to ascertain the extent to which lead shields were sold and used was made in upstate New York by the Department. The report, published in its bulletin, *Health News*, for January 30, 1939, states that: "Investigations were made in 159 cities or villages and covered 470 drug stores and a number of hospitals and physicians." It was found that apparently the use of the shields is not very common but that they are rather easy to secure. The report concludes that: "Since there are available other and safe therapeutic agents which have the same effect as lactate of lead but which do not carry the potential health hazard that lead lactate conceivably does, the use of lead nipple shields should be abolished."

The United States Department of Agriculture has recently banned the transportation of lead nipple shields in interstate commerce.

Public health nurses should be informed on the hazard in the use of lead nipple shields and the recognition of the danger implied in these regulations for control of their sale.

*"Fatal Lead Poisoning in a Nursing Infant Due to Prolonged Use of Lead Nipple Shields," by Murray H. Bass and Sidney Blumenthal, *The Journal of Pediatrics*, November 1939, page 724.



Nursing in Yugoslavia

By DESANKA PEROVICH

IN THE epic poems of Yugoslavia belonging to the fourteenth century we can trace our first nurse. A beautiful poem describes her attending the wounded on the battlefield of Kosovo in the year 1389, when one part of our country in the battle against the Turks lost its liberty for five hundred years. A long space of time these five hundred years! During this period bedside care was done by religious orders. The history of our public health nursing as well as our general public health work in the modern sense begins after the World War.

The first school for preparing public health nurses was founded in Zagreb in 1921 with a one-year course in the prevention of tuberculosis. The second course was prolonged to 18 months, and the third to two years, with a more comprehensive program. Since 1930, how-

ever, there has been a uniform training system in the whole state. The courses last three years, giving preparation for bedside care and public health nursing. The minimum requirement for admission to the school is four years of secondary school, or "small matriculation" as it is called.

Besides the school in Zagreb, there are three other public health nursing schools in the state. Each of them started with the preparation of nurses for local needs, such as the protection of infants or the prevention of tuberculosis. But since 1930 they all have the same general curriculum.

At the present time about eight hundred trained public health nurses are working in public health and social institutions throughout the state.

Hospital nursing in Yugoslavia is mostly done by religious orders. Speak-



The rural health center



The nurse teaches the young mother



She knows how to bathe her baby

ing generally, bedside care is a sore point in our country. It does not progress as rapidly as public health nursing, but there is some improvement to be noticed since 1930 when the education for hospital nurses was prescribed by law in the form of an 18-months' course. Later the training was reduced to one year.

Yugoslavia has a population of 15,000,000, of which 80 percent is rural. It is evident that the public health work in Yugoslavia deals mostly with rural problems.

Immediately after the World War a Ministry of Public Health was formed in Belgrade. The state assumed the whole responsibility for the improvement of health conditions. We now have a very good public health organization which was initiated by Dr. A. Stampar, head of the Health Section of the Ministry of Public Health. The state is divided into nine provinces. Some changes in organization are going on at present.

In the capital of each province is a center for public health called the Institute of Hygiene. The next unit is the public health home. These are usually situated in cities of over ten thousand population. Every such home has to cover an area of several districts and is staffed with full-time doctors and public health nurses. The smallest unit is the rural health center. This is the outpost, which employs a full-time nurse and usually a part-time physician. The entire public health work is centralized in the Central Institute of Hygiene in Belgrade.

In Zagreb a School of Public Health was established in the year 1927 with the help of the Rockefeller Foundation, to do research work for the improvement of public health and to train personnel.

SERVICES OFFERED TO FAMILIES

Our nursing program includes prenatal and postnatal care, infant welfare, protection of the preschool and school

child, prevention of communicable diseases, health teaching, and bedside care on an instructive basis only. Out of this generalized nursing program two branches stand out—prevention of tuberculosis and infant protection, which are the most urgent problems in our country. If we consider that the infant mortality in Yugoslavia was 167 per thousand live births in 1932 and that the mortality from tuberculosis is still excessively high, it is no wonder that the major part of the work is concentrated upon those two branches.

Prenatal work has developed nicely in the last few years. School health work is even better. But it is the preschool child who is neglected, and very little is done for this important age-group.

Our nurse-nutritionists, who are the only specialists in our nursing group, carry on a fine piece of nutrition service. They work exclusively in the villages, giving one-month courses in nutrition and home hygiene. The pioneers in this work as well as in other branches of nursing were trained in United States and in Canada, where they were sent by the Rockefeller Foundation.

The nurses do group teaching in the form of mother and baby courses which last two weeks.

MANY SOCIAL PROBLEMS

Our public health nurses have to do social work too because it is impossible to divide health and social work in our conditions. Sometimes nurses even have to do direct relief work though we try to avoid it as much as possible. These are some examples of our problems:

The father of one family, a workman with an open case of tuberculosis, has not been fit for work for six months. The allowance from the insurance company is exhausted. There are four children in the family, the youngest 11 months of age and the oldest nine years old. The family lives in a one-room lodging with a kitchen range and two beds in the same room. The rent has not been paid for several months. The family has to move. Their whole income

He takes his sun bath



She makes the baby's bed



Baby plays while mother weaves





Two little maids from school

consists of a few dinars* that the wife earns occasionally. There is no money, no steady lodging, no food, poor clothes, and sickness in the family.

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The father of another family is an unqualified workman without employment. The mother takes care of seven children. The oldest child is 13 years old. The two youngest are twins, ten months of age. The family lives in an old barrack, literally empty. The whole furniture consists of a bed with few rags on it and without even straw, a table, and a kitchen range. The wind blows through the chinks. It is winter time. There is no wood. The children are barefooted with some rags on their shivering bodies. The little twins have had dysentery and just came out of the isolation hospital. One boy 11 years old who attends school left home a week ago, strolling around. No wonder that such a home does not attract him! Such was the situation when the nurse came in to see the family.

Would anybody be able to do pure health work here? Since there are no social workers in the rural areas to help the families with these problems, the nurse has to do the best she can.

The most responsible work for a nurse is in the rural health center where she works, so to say, alone. The physician is generally part-time. He usually comes twice a week, holds a general clinic, gives directions to the nurse for minor treatments, and leaves the village. The nurse is again alone. There is no physi-

*One dinar is worth about two cents in American money.



Peasant women harvest the crops

cian, no hospital, no medical help whatsoever. The whole responsibility for community health lies with her.

She first organizes the peasant women into a society for protection of public health, through which she educates and guides them. She divides the village into several districts. Each member has the responsibility for one district. They have to attain the maximum of hygienic living which is possible in such conditions, and so they set a good example to their neighbors in the way they manage their homes, households, and gardens.

The nurse visits every pregnant woman in her district. She gives her instructions in the hygiene of pregnancy and helps her prepare what is necessary for the delivery and for the coming baby. If the nurse suspects there is something wrong with the mother she arranges for her to see a specialist. The delivery is done by a midwife, who has had an eighteen-months' course of training. She takes care of the mother and baby for nine days after delivery. After this the nurse assumes the whole responsibility for their health. She has the baby under supervision, as a routine, until he is a year old. If he is well, she discharges him then.

Then comes the long gap from the first year of life until school age. All the nurse does for the preschool child in the village is to take care of him if he is



An old village well



Homeward bound

sick. If the child is well the nurse only gives occasional directions to the mother and tries to have the child come every week to the public bath. Though the nurse realizes the importance of guidance of the preschool child it is quite impossible for her to do it considering her load of work and the large area she covers.

The nurse usually has more than one elementary school in her district. She coöperates with the teachers and assists them wherever they need help. It is her duty to arrange for complete physical examinations and she tries to get the defects corrected. She organizes hot lunches for the children. Once a week the children come to the public bath in the health center.

The nurse provides the school with health literature and posters. From time to time a good health film is brought to the school. As a rule the nurses do not give health talks in the classes but they encourage the teachers to do it and help them with literature and suggestions. It is the nurse's duty to improve the sanitary conditions in the school: to see that there is safe drinking water; hand-washing facilities; sanitary toilets; proper lighting, ventilation, and heating; and proper cleaning of the school building. The nurse sees the children in their homes, and keeps constantly in touch with the parents.

The most difficult work is with tuber-

culosis because we have not sufficient hospital beds for the isolation of open cases, and especially because we have no provision for them in the rural areas.

WORKING CONDITIONS OF NURSES

The majority of our public health nurses are employed by the state. Some are employed by the cities and workmen insurance companies. Their salary is small, especially compared with the American nurse's salary. They begin with 1000 dinars a month—about \$20—without any additional allowance except lodging if there is a room available in the center where they work. The nurses wear uniforms which they buy out of their salaries.

The only advantage is that our nurses have the right of pension. This right begins after 10 years of service and increases until they reach 35 years of service, when the amount of pension is practically equal to the salary. Nurses have a paid vacation beginning with 10 days a year; after five years of service it is increased to 20 days. If a nurse gets sick she goes on sick leave with full salary as long as she is ill, up to one year.

All qualified public health nurses are organized in the Yugoslavian public health nurses' organization which was accepted as a member of the International Council of Nurses in 1929 at Montreal, Canada.

Diabetes in the Child

By PRISCILLA WHITE, M.D.

The nurse should be familiar with the principles underlying the treatment of juvenile diabetes, the complications which may occur, and the prognosis

ALTHOUGH the nurse may not see many diabetic children, each juvenile patient is a complex and interesting problem in medical and psychological adjustments. The incidence of the disease in childhood in contrast to adult life is low. We estimate that only one child in eight thousand contracts diabetes under fifteen years of age and there are not more than twenty thousand juvenile diabetics in the entire country. The onset in childhood, unlike adult experience, often is acute, and the early course is so virulent that the first recognition of diabetes in the child may be when he is in coma. The younger the child, the more often is this true. A drowsy, thirsty, cachectic infant should suggest the diagnosis of diabetes. The symptoms are the same in the child as in the adult;* but one more often sees visual disturbances, especially alternative near and far vision, and in addition finds school failure.

ETIOLOGY

It is in the juvenile population that nurses and physicians can stress the importance of the inheritance of the disease. The older patient has already married and founded a family, but this generation is most susceptible to eugenic teaching. Because diabetes is transmitted as a recessive the lesson is difficult to teach. The lay mind thinks

mostly in parent-child (dominant) transmission and does not appreciate that a recessive trait can lie sleeping for several generations. An explanation of the actual evidence upon which the theory is based often helps the family to understand. The evidence in favor of the theory rests upon (1) the demonstration of the simultaneous occurrence of diabetes in similar twin mates (2) the statistically significant excess of the incidence of diabetes in blood relatives of diabetics as compared with those of control nondiabetic populations (3) the demonstration of the Mendelian recessive pattern in the siblings of over 1000 of our patients selected at random and in 300 tested families.

However, since diabetes is not evident at birth or soon thereafter but follows an age behavior, in recent years its expression has been attributed to complex endocrinal factors. The best example of this is seen in the diabetic child whose onset occurs commonly at puberty and who at onset of the disease shows presumptive evidence of hyperactivity of the pituitary because his stature is greater than the average for his chronological age, his bone and dental developments are advanced, his basal metabolic rate is elevated, and puberty is precipitated. Nearly equally as suggestive of hyperactivity of the pituitary is the peak in age of onset in adults, which is fifty years.

The research by Houssay, Young, and others in regard to the pituitary gland

*See "Treatment of Diabetes by Diet and Insulin," by Dr. Howard F. Root, *PUBLIC HEALTH NURSING*, February 1940, p. 95.

leads us to the belief that the gene works through hyperactivity of the pituitary on the pancreas and tissues.*

The research of Young and Houssay has stimulated attempts to alleviate the course of diabetes by inhibition of the pituitary. Radiation and estrogen and androgen therapy have been tried. No successful results have been proved, but further attempts are stimulated because carefully controlled experiments such as those of Professor Zondek have proved that certain of the pituitary hormones can be inhibited, namely, gonadotropic (those affecting the sex glands) and growth. The inhibition of the latter was successful to the extent of producing symmetrical dwarfism. An objection is encountered in the search for the diabetes-producing factor here. Transient hyperpituitarism produced permanent, irreversible changes in the islets so that inhibition of the pituitary gland after the establishment of the disease would not really cure it.

PREVENTION

The experiments in diabetes prevention should be continued and carried on, not in actual diabetics but in known potential diabetics; namely: similar twins of diabetics, or the offspring of two diabetics. This discussion brings out one of our greatest needs, that of a test for latent diabetics—perhaps a biological test since the standard glucose tolerance test is often inadequate in this respect.

Prevention of diabetes at present can only be sought by outbreeding. First, diabetics should be advised to marry true nondiabetics; second, the offspring of this union should also marry only true nondiabetics. The children of a union of a diabetic and true nondiabetic will all be carriers, thus increasing the chances of inheritance of the disease in

the population, but the marriage of these children to true nondiabetics will minimize the chances of double doses of genes and reduce the chance of spreading diabetes to practically nil.

DIAGNOSIS

A real pitfall in diagnosis in juvenile diabetes arises from the fact that glycosuria is very common in childhood. If one examines enough specimens of any healthy child, one may find up to a yellow-green reduction with the Benedict test. Therefore, many children are placed needlessly upon a diabetic regimen today. The diagnosis must not be made unless an excess of sugar in blood and urine is demonstrated.

TREATMENT

To the fundamental principles of treatment in the adult—diet, insulin, exercise, and education—for the child we must add protection.

The prescription of the diet for the diabetic child is the physician's responsibility, but the nurse should be familiar with the principles underlying it. Although surface area is the deciding factor for caloric requirement, for simplicity, calories may be prescribed by age—1000 at the age of one, plus 100 for each year of age until cessation of growth. Since this occurs at the age of 12 in girls and 19 in boys, 2200 calories is the maximum diet for a girl and 2800 for a boy. The importance of restriction of calories in the diabetic adolescent girl cannot be overemphasized, because female adolescent obesity is one of our difficult problems.

A diet high or low in carbohydrates is prescribed according to one of two theories—that stimulation of the pancreas alleviates the course of the disease, or that rest of the pancreas accomplishes this result. We have, in recent years, favored high carbohydrate diets, the gram ratios of carbohydrate, protein, and fat for the child being $C_{2-3}P_{0-1}F_{0-1}$.

*See "Diabetes—A Public Health Problem," by Dr. Elliott P. Joslin, *PUBLIC HEALTH NURSING*, January 1940, p. 5.

As an empirical rule the figure for carbohydrate is ten percent of the figure for the total calories. For example, the diet for age 9, either boy or girl, will be 1800 calories according to our age rule. The carbohydrate will be 180 grams; the figure for fat one half, or 90 grams; and the protein a little less, or 80 grams.

Not only must we answer the questions how much and what to feed the child but also how often. Thirty grams of carbohydrate are subtracted from our final figure and given as ten grams in the middle of the morning, afternoon, and on retiring. Thus a typical diet for the day is:

Breakfast

Egg—1
Bacon—15 gms. (3 slices)
Oatmeal—15 gms. dry weight ($\frac{1}{2}$ cup cooked)
Butter—10 gms. (1 pat)
Cream—60 gms. (2 oz.)
Orange—100 gms. (one small)
Bread—30 gms. (1 slice)
Milk—120 gms. ($\frac{1}{2}$ glass)

Lunch and dinner

Meat—60 gms. (1 average serving)
Five percent vegetables—150 gms.
Butter—10 gms. (1 pat)
Orange—150 gms. (1 medium)
Potato—75 gms. (one half)
Bread—30 gms. (1 slice)
Milk—180 gms. ($\frac{2}{3}$ glass)

Mid-morning, mid-afternoon, and before retiring
2 soda crackers

Since the diet contains fresh fruit, milk, vegetables, meat, and cream, the vitamin and mineral content should be adequate.

INSULIN

All diabetic children require insulin, preferably from the day of recognition of the disease. Today's question is what type of insulin to employ. This again, is the physician's responsibility, but the problems involved are of interest to the nurse who may be charged with administering the insulin or teaching the family to do so. The choice of the type of insulin is made from among several different types of rapidly acting insulin or one slowly acting kind. The rapidly

acting insulins are more or less interchangeable; they are amorphous and crystalline. Although protamine zinc insulin is the only slowly acting insulin marketed, others are being studied—peptone, histone, and hexamine. These are all valuable attempts to produce a combination of long duration of action and immediate availability of insulin.

The practical application of protamine zinc insulin in a large series of patients shows that only ten percent of the children do well with protamine zinc insulin alone and ninety percent require both slowly and rapidly acting insulin. It is our custom to prescribe both types of insulin as separate injections before the breakfast meal. The new patient receives insulin according to age—at five years, 10 units; at ten, 20 units; at fifteen, 30 units. Long-standing juvenile diabetics transferred to protamine zinc insulin receive the usual breakfast dose of rapidly acting insulin and twice that dose of protamine zinc insulin. Readjustments are made on the basis of pre-meal and retiring tests.

The disadvantages of protamine zinc insulin—much outweighed by the advantages—must be kept in mind. They are two: (1) the slow release of active insulin from the protamine compound, necessitating the accessory dose of rapidly acting insulin, and resulting in the increase in blood sugar after the meal (2) the cumulative action which if neglected favors the occurrence of insulin reactions due to a deficiency of blood sugar. With increased experience, reactions are produced less frequently and those induced are of less severity.

The standards by which we judge that diabetes in the child is under control are (1) maintenance of ideal weight, normal vigor, and interests (2) freedom from symptoms of diabetes (3) freedom from signs of diabetes as shown by a normal blood sugar before meals and urine test not more than yellow-green in twenty-four hours.

COMPLICATIONS FOLLOWING INSULIN

Complications of insulin treatment are hypoglycemia, fat atrophy, and induration.

Hypoglycemia

Because of greater activities and smaller storage places for glycogen, insulin reactions (low blood sugar levels) occur more frequently in the child than in the adult. The most common warning signs or symptoms are sudden change of disposition or behavior, listlessness, double vision, headache, pallor, and sweating. In the severest forms they are associated with nausea, vomiting, unconsciousness, or convulsions.

The treatment consists of correction of the cause. The blood sugar may be elevated by giving sugar by mouth, or by administration of glucose under the skin (five percent) or by vein (fifty percent). The parents may be taught the use of the contra-insulin hormones—adrenalin (0.3 cc.), pitressin (0.3 cc.), and pituitrin (0.3 cc.).

Reactions due to rapidly acting insulin are seen four hours after administration, or with present treatment at 11:00 a.m.; those seen with slowly acting insulin after twenty-four hours, or at 6:00 a.m.

Fat atrophy

Fat atrophies (symmetrical lesions seen near or at the site of injection of insulin) to our surprise occur more frequently with protamine zinc insulin than they did with regular insulin. Thirty percent of our children and many female adults exhibit this local disturbance. The cause and treatment are unknown. Spontaneous recovery often occurs. The lesion does not appear to be due to trauma or the chemical reaction of insulin, since it may occur after one injection, and follows acid, alkaline, or neutral insulin. Our only advice is to encourage children and women from the onset of insulin therapy to administer it in areas unimportant from the standpoint of appearance.

Insulin induration

Insulin induration (disfiguring tumor-like swellings) which might be expected with protamine zinc insulin because it is crude compared with regular insulin, is more rarely seen. It is prevented by the scattering of sites of injection. Children like their insulin in one hard, painless spot!

Epilepsy

Epilepsy, though not a proven complication of hypoglycemic insulin reactions, may be related to them. Perhaps latent epilepsy is revealed by insulin. Our incidence of epilepsy proven by electro-encephalography is high.

EXERCISE

Exercise is of most value if timed and constant in amount day in and day out. Exercise is especially desirable after meals. Pre-meal rest is desirable to avoid reactions from insulin and the increased utilization of sugar which results from exercise.

EDUCATION AND PROTECTION

Education, so helpful for the adult patient, is of less value with the child—who learns readily but lacks the wisdom to follow the rules. The child has been known to demonstrate to doctors the diagnosis and treatment of coma and enter the hospital a few weeks later with this complication. He is impressed with his own immunity and immortality and thinks the lessons apply to the other person but not to himself. The solution to this problem has been the establishment of camps and school units to protect the children against themselves.

In the first year of diabetes the child takes pride in his adherence to the routine; later he is palled by the vision of a timed existence and resists treatment. This period of maladjustment is replaced by a good adjustment as the child approaches adult life and attitudes.

The juvenile patient cannot be well managed without a knowledge of some of his tricks, such as the substitution of

water for urine, or another specimen for his own. A record kept by the child does not have as much value as the one kept by the adult patient. Excitement over a single poor test at home leads to deception. It is better to correct the condition, if it occurs, with extra insulin in small doses and watch the next day's pre-meal specimens to see whether there is a true change or one merely the result of a dietary indiscretion. Diet-breaking is not a moral issue!

COMPLICATIONS OF DIABETES

Coma, infections, and hepatomegaly or enlargement of the liver are complications which are largely preventable and correctable. The cause and treatment of the severe neuritis occurring in some diabetic children remain unknown. A few new clues about the etiology of arteriosclerosis present themselves. Dwarfism can be successfully treated.

Coma

Diabetic coma since the era of protamine zinc insulin has been mild in type. The symptoms are the same as those in an adult.* As soon as the warning nausea, vomiting, and hyperpnea occur and the diagnosis is made, the child in a hospital receives 10 to 40 units of insulin every half hour, fluid—normal salt solution up to two quarts by clysis, and gastric lavage. The incidence of coma is ten times greater in the child than in the adult, but the prognosis for recovery except for patients *in extremis* at the beginning of treatment is nearly 100 percent.

Infections

Infections of three types have menaced the lives of young diabetics, but today they are decreasing in importance. Tuberculosis, the susceptibility to which is no greater than that of the general population, is now seen less often. No new case has been revealed in three

years in our patients under twenty years of age, and its importance as a cause of death is decreasing. It is true that it still ranks second to coma as a cause of death, but since tuberculosis ranks first among the diseases as a cause of death in all children between the ages of five and twenty, this is to be expected.

Infections of the skin and urinary tract, like tuberculosis, were increasing as a cause of death in the young. However, they are now decreasing and since the era of chemotherapy no longer fill us with dread.

Hepatomegaly

Hepatomegaly, a large painful liver causing abdominal protuberance, is often associated with dwarfism. The prevention and cure of hepatomegaly occurred before the cause was revealed. This complication, nearly restricted to childhood diabetes, is prevented and cured by protamine zinc insulin. The nature of the enlargement of the liver is not known. It is possibly fat or glycogen or water stored abnormally.

Degenerative lesions

The severe forms of neuritis, associated with paralysis and pain usually occurring at night, occur in only one percent of our children. Vitamin B₁ therapy has not been successful. Primary anemia has been observed only once in our childhood diabetics. Nocturnal diarrhea occurs more frequently in young diabetics and responds to continuous liver treatment (3 cc. weekly intramuscularly).

Degenerative complications

Retinitis, retinal hemorrhages, cataracts, and arteriosclerosis occur in young diabetics. Retinitis and retinal hemorrhages may be reversible, and cataracts are removable, so that arteriosclerosis is the most serious of this group. The possible causes suggested are (1) lack of diabetic control (2) heredity (3) endocrine imbalance. All of our children who developed it had periods of uncontrolled diabetes. An inheritance

*See "Complications of Diabetes," by Dr. Alexander Marble, PUBLIC HEALTH NURSING, March 1940, p. 155.

of a stigma is not an illogical belief; other degenerative stigmata are inherited in diabetes. The endocrine origin is suggested by hormonal imbalance in pre-eclamptic toxemia, the clinical picture of which is not unlike the final picture of nephrosclerosis in juvenile diabetes. The child who has developed the most severe forms of arteriosclerosis is most often the one who is dwarfish or infantilistic.

Dwarfism

Retardation of height has been observed in ten percent of our diabetic children. It appears to be unrelated to control of diabetes or caloric prescription. We believe these retarded children are hypopituitary dwarfs, and they respond to the administration of pituitary extracts with or without thyroid extract. The growth curve can be

broken at any age so long as the epiphyses are open. But growth is proportionate only if treatment is started early; those patients treated late maintain infantile proportions and consequently do not have a perfectly normal adult appearance.

COURSE AND PROGNOSIS

The progressive course of juvenile diabetes is more apparent than real. The total dosage of insulin in units is increased with age but not with body weight. An occasional arrested case requiring no further treatment occurs.

Thus the past seventeen years have taught us that survival, growth, and development of the diabetic child are assured. Many serious complications may occur but the majority are correctable and preventable.

"THE BROADENING CONCEPT OF MATERNITY"

A Five-Day Institute for Nurses

MATERNITY is not just a piece of life to be lived separately from the rest of life, and the goal of good maternity care is greater than the successful termination of one pregnancy. The coming of a baby is life in the most real, most human sense. For this reason everything that happens in life may have a bearing on maternity: health before marriage; the adjustments which young couples make to each other; decisions about how many children they shall have and when to have them; the problems of sterility and abortion. In short, the whole attitude of young people toward life.

Because of this broadening concept of maternity, the Maternity Center Association announces a 5-day institute to be held at the headquarters of the Henry Street Visiting Nurse Service at 262 Madison Avenue, New York, N. Y., May 6-11 inclusive.

The subjects for discussion will be: the newer developments in obstetric practice; parent education, with emphasis on fathers as parents; education of the public, considering all media—the spoken word, printed material, motion pictures, radio broadcasts, charts, and exhibits; and the place of the nurse in this ever widening field.

The institute is open to all public health nurses in the eastern states. The fee is \$5 and applicants will be registered in the order in which paid applications are received. Registration will close on or before April 25. The number who may attend has been limited to permit free discussion. Tickets not transferable. To register, make application to the Maternity Center Association, 654 Madison Avenue, New York, N. Y.

The School Nurse Plans Her Program

By ELLA E. McNEIL, R.N.

The school nurse plans her program jointly with others responsible for the child's health. They survey the needs, define the objectives, and determine the activities

“WE HAVE just employed a school nurse. Please suggest a program for her first year.”

“I have been working in this county for five years. How much of my time should be spent on school work, and what new health projects would increase interest?”

Such requests for help in planning school nursing programs are frequently received by agencies offering consultation service on public health nursing. They come from rural and urban communities; from generalized and specialized nurses; from school administrators; and from board and committee members. The need for more and better planning is recognized. But no one has designed a pattern which will fit all situations, or even those which are apparently similar. There is about as much chance of devising such a pattern as there is of finding a dress of one size, style, color, and material which will fit and be suitable for all women—tall and short, fat and thin—to wear on all occasions. Just as the type of dress which a woman buys depends upon the purpose for which she needs it, her present wardrobe, the amount of money which she has to spend, and the other things which she wants or needs, so the nursing program depends upon the existing services and the needs, interests, and resources of the community.

In order to select a pattern for anything we should know what we wish to make and what materials we have.

Much of the confusion in planning school nursing programs is due to vague, poorly-defined, or conflicting objectives. If it is agreed that the school and the community desire healthy children who are learning to assume increasing responsibility for individual, family, and community health, then we can decide how the public health nurse can best contribute to this objective.

PLANNING IS A JOINT RESPONSIBILITY

Even a well prepared, experienced school nurse with complete statistical information about the school and the community needs help if she is to plan a sound program. Determining the objectives and outlining the plan for reaching them must be a joint responsibility. The programs, policies, personnel, and general objectives of the department of health and of the schools must be considered as well as the needs of the community and the amount and kind of public health nursing service available.

Regardless of the agency employing the nurse, responsibility for the health of the school child will always be shared by the parents, the personal physician and dentist, the school, the department of health, and other social and health agencies; and each of these groups should be represented in the planning of the program. School nursing is just one phase of the community program of health education and health service, and to be effective the nurse's work will be considered a part of the whole. To plan the school nursing service without con-

sidering the whole community health program is as absurd as to design sleeves without regard to the dress of which they are to be a part.

DETERMINE THE OBJECTIVES

The answers to the following questions will give some guidance in outlining the objectives of the school nursing program:

1. Does the health program include mental, emotional, and social health as well as physical health?

2. Why is the school interested in the health of its pupils?

3. Why is the department of health interested in the health program of the schools?

4. If the school is primarily interested in education, what are its functions in regard to health services or a healthful environment?

5. How does the home influence the health status, attitude, knowledge, and behavior of a school child?

6. What is the responsibility of the school for the education of parents?

7. What is the responsibility of the school for interpreting to the community its health needs?

8. Is it possible to plan an economical and adequate health program for children of school age without an effective infant and preschool health service?

9. What is the purpose of periodic health examinations or inspections of school children?

10. What is the purpose of school health records?

11. Is it more important to have all defects corrected promptly or to have parents and children appreciate the value of medical care and assume as much responsibility as possible for securing it?

12. Is the private physician considered the final authority on all individual health problems?

13. If the service is generalized, is the school work considered important in

itself or only as a means of making contacts in homes?

14. Is it more important for the nurse to carry on a constructive health program than to be available at all times to relieve the principal, physician, teachers, or health officer of time-consuming details which do not require professional service?

15. Is the school health education program planned to meet the requirements of the pupils or of the curriculum?

CONSIDER THE LOCAL FACTORS

When the objectives of the school nursing service have been outlined and the policies of the school and health department are understood, the nurse may begin to plan her program. Obviously she will not be able to accomplish everything the first year, and a tentative plan for several years is desirable.

The following are some of the factors which must be considered:

1. The total school population per nurse.

2. The number, size, and location of the schools.

3. The transportation facilities, roads, and weather conditions.

4. The amount of medical and nursing service available for school work.

5. The qualifications for school health work of the nurse and of other school and health personnel.

6. The state laws and local ordinances affecting the program.

7. The school and community facilities for health education, and for health and social services.

8. The special interests of pupils, parents, teachers, and private physicians.

9. The special needs as indicated by health examinations and inspections; attendance records; reports from teachers; statistics on mortality, morbidity, accidents, and immunizations; the nurse's observations in school and health education, and for health and social workers.

10. The feasibility of having children examined by private physicians.

11. The possibility of having parents come to school for individual or group conferences and of their being present for the examinations or inspections of their children.

Tentative plans for the school year should be made the preceding spring.

PLAN THE ACTIVITIES

Health education

Health education activities constitute the major part of every public health nursing program. This does not mean that the nurse needs to give classroom health talks or teach health classes. She is constantly teaching health in the school, the home, and the community. She confers with teachers about the health needs of their pupils and suggests ways of meeting them. She gives them information secured from health records; from home visits; from conferences with pupils, physicians, dentists, or social workers, which will guide them in planning a health program.

She also helps the teacher plan her instruction so that it will be accurate and timely by giving her suitable, authentic reference material on the health needs of children, on prevalent diseases, or on recent research in the field of health. She may enlist the teacher's interest in developing teaching units which will promote a community health project such as diphtheria immunization or tuberculosis case-finding. Or she may ask her to encourage the use of inexpensive, protective foods.

Through all of her health conferences the nurse emphasizes the value of health and the importance of maintaining it through healthful living. She also teaches the value of medical, dental, and nursing services and when necessary helps families to secure such care. The nurse's contribution to education is most effective when she is well prepared and has adequate time for satisfactory conferences.

Control of communicable diseases

By a thorough understanding and careful interpretation of school and health department policies the nurse assists in the control of communicable diseases and promotes good school at-

tendance. It is doubtful if the routine visiting of children who have been absent two or three days is an efficient and economical use of nursing time. Such visits are made too late to secure early diagnosis, isolation, or medical care. In her conferences the nurse stresses the importance of observing significant symptoms and immediately isolating and securing medical care for pupils suspected of having a communicable disease.

Instruction of teacher in health observations

In addition to helping teachers to recognize the symptoms of communicable diseases the nurse assists them in making periodic inspections and in the continuous observation for evidence of good health or of deviations from normal health. Practically all of the health activities in school offer an opportunity for clinical instruction of teachers, pupils, and parents by the nurse or physician. As with all clinics, every precaution must be taken to avoid embarrassing the pupil and to place the emphasis on health rather than on diseases or defects.

Pooling information on the child

When the information of teachers, nurses, and physicians (school, private, or clinic) is pooled, an educationally sound and effective program is possible. This may seem to require time, but the nurse can then make her home visit or conduct her interview with the parent at school with the convincing assurance which is possible only when she has authentic information. She will support rather than refute the advice given by her colleagues.

Emergency care of pupils

The nurse usually has some responsibility for seeing that pupils who are ill or injured at school receive proper emergency care. This does not require that she must personally treat every scratch. She should see that policies regarding such care are established and under-

stood; that responsibility is delegated to some reliable person; that proper equipment is available; and that arrangements have been made for transporting patients to their homes when parents cannot be reached. Pupils are taught to treat minor injuries and to know when medical care is necessary and how to secure it.

Shall the nurse teach classes?

Should the nurse teach health classes in the high school? The answer to this question depends upon whether she is qualified, whether other equally or better qualified teachers are available, and whether her contribution in this field will justify the necessary reduction in other phases of her program. Frequently better results can be accomplished through individual conferences and home visits. If classes are taught, adequate time must be allowed for preparation. When a limited amount of time is available for teaching, it may be advisable to spend it with a class of young mothers rather than with students.

MAKE A SCHEDULE IN ADVANCE

The schedule of the school nurse will vary greatly according to the situation, but a schedule is important. It is helpful to teachers, parents, physicians, and other workers to know where the nurse expects to be at definite times. It should be understood that her program is flexible and must be adjusted to meet emergencies, but that she will make every effort to notify the school of necessary changes. An interpretation of "emergency" may be needed and an attempt to adhere to the schedule may reduce the number of emergency calls.

The steps in making a schedule include the following:

1. Fixed dates which affect the nurse's program and which cannot be changed are noted. These will include the dates for the opening and closing of schools; school holidays; conventions; annual meetings; and regularly scheduled

projects, examinations, clinics, and conferences which the nurse must attend. Regular activities are planned around these dates.

2. The schedule should allow time for keeping adequate records and reports; doing other necessary office work; making home visits; conferring with parents, teachers, pupils, physicians, and others; and attending meetings of teachers, parents, and community agencies.

3. If a nurse in either a rural or urban community is responsible for all of the public health nursing work in her district and plans the rest of her activities around her schedule for visiting schools, care is necessary to avoid planning a heavier school program than she will be able to carry out.

4. A tentative schedule should be prepared and submitted to school and health administrators and to the health committee for suggestions or approval.

5. The final schedule is completed as early as possible, and a copy is sent to the superintendent of schools, the health officer, the school principals, the teachers of the one-room schools, the chairmen of health committees, and other health and social workers who would be interested. In small communities, nurses frequently send a copy of their schedule to each member of the employing agency and to the president of the parent-teacher association.

6. Visits to schools should allow time enough for constructive work even if they must be made less often.

THE RURAL NURSE'S SCHEDULE

It is especially important for rural nurses to plan their work carefully. Frequently the rural nurse divides her area into four districts and spends one week a month or a certain day of each week in each district. A full week in one district permits more concentrated work. A certain day of each week in a district, on the other hand, means that the nurse will be there more frequently

and is less apt to be called to the district when she is in another part of the county. If teachers and parents know when the nurse is to be in a school, conferences can be arranged which will save much time for the nurse and may be more effective than home visits.

If Wednesday—or some other day during the week—and Saturday morning are left free from any regular appointments, it will be easier for the nurse to make home calls regularly and still follow her schedule.

In counties with one-room schools where there are few teachers' meetings, the nurse may plan occasional group meetings for teachers and board members who wish to consider school health problems. Bulletins and personal letters or form letters may help the nurse keep in touch with rural teachers.

The nurse who has been very busy with a specialized school nursing service and is now asked to carry a generalized program may find it especially difficult. She will first eliminate activities which are unnecessary or ineffective. Next, with the help of the school health committee, she will decide what work for-

merly done by the nurse can be done by someone else. The need for some of the school work may decrease as the health supervision of the whole family is intensified. The most essential activities for attaining the objectives of the school service will be included in the generalized program.

SUMMARY

The success of the nurse's service is dependent upon her relationships with other individuals and agencies. She coöperates with others in surveying the needs, deciding upon general objectives, and determining what her contribution will be. She lets her co-workers know how, when, and where she is working and gives them an opportunity to suggest needed services or changes in her program.

Periodically the public health nurse analyzes her program and evaluates the results to see if she really has been doing the things which will accomplish her objectives. Even the best program is apt to be like her favorite summer dress; when she looks at it the next year, it is not as good as she thought it was and needs quite a bit of remodeling.

NURSE PLACEMENT SERVICE



announces the following placements from among appointments made in

the various fields of public health nursing. As is our custom, consent to publish these has been secured in each case from both nurse and employer.

*Lena Hevey, Head Nurse, Metropolitan Life Insurance Company, Malden, Mass.

*Joanna Moran, County Nurse, Department of Public Health, Burlington, Vt.

Frances Rice, County Nurse, Casey County Health Department, Liberty, Ky.

Dorothy Moomaw, County Nurse, Boyd County Health Department, Ashland, Ky.

*Ann Gabriel, County Nurse, Jackson County

Health Department, McKee, Ky.

*Elsa Juhre, Infirmary Nurse, Colorado College, Colorado Springs, Col.

*Mercedes Duncan, School Nurse, Public Schools, Paris, Ill.

*Margaret Therriault and Josephine Baca, Staff Nurses, Henry Street Visiting Nurse Service, New York, N. Y.

*Mary Lammers, Staff Nurse, Department of Public Health Nursing, Greenwich, Conn.

Carol Martin, Staff Nurse, Visiting Nurse Service, Madison, Wis.

Annette Boufford, Staff Nurse, Atlantic Visiting Nurse and Tuberculosis Association, Atlantic City, N. J.

Philomena Conway, Staff Nurse, State Department of Health at Greenbrier County, Lewisburg, W. Va.

*The N.O.P.H.N. files show that this nurse is a 1940 member.

Occupational Therapy in Arthritis

BY CHARLOTTE BELL, O.T.R. AND LORING T. SWAIM, M.D.

A discussion of the principles of occupational therapy in the treatment of chronic arthritis

OCCUPATIONAL therapy plays such an important part in the treatment of chronic arthritis that we believe the occupational therapist must work in close coöperation with the physical therapists and the physicians in selecting types of work for the patients—work which will best promote normal function in the joints and muscles involved.

Although the chief object of this form of therapy is to increase or preserve function, the recreational aspects are extremely valuable. The clinical course of arthritis is so prolonged and the improvements so gradual that patients are inclined to become discouraged. Occupational therapy provides an outlet from this unhealthy attitude. Patients look forward to the work from day to day. They quickly coöperate in its purpose and become extremely interested in the outcome. There is a great satisfaction in creating or completing a useful article, and the patients are fully aware of and pleased at the physical gain which they see is taking place.

In arthritis, occupational therapy is prescribed by the doctor, usually when the active disease is arrested. But even during the semi-active stage, light work can be of real value to the joints. The occupation is light at first and carefully chosen for the effect on specific joints and muscle groups. It is important to utilize the greatest possible range of motion and all the available muscle strength. Work is limited to a few minutes at first and increased according to the physical ability of the patients.

Fatigue must be avoided because of the danger of lowering the patient's resistance and producing a harmful effect on the abnormal joints and weak muscles.

MANY CRAFTS UTILIZED

Emphasis should be placed on the need for a well trained and resourceful occupational therapist in carrying out a program for the arthritic. Recourse to many different crafts is necessary in order that they may be adapted to the functional needs as well as to the personal interest of the patient. We have found that knotting and weaving offer the most satisfactory exercise for the upper extremities since they require varied use of both arms. Pottery, light carpentry, and wood-carving are also practical, and like the above crafts, are adaptable to varying needs. For the lower extremities, jig-sawing and bicycle-riding provide exercise for the hips, knees, and ankles. Sewing machines and foot-power lathes are also useful. For combined use of the upper and lower extremities, a floor loom is most helpful. There are numerous other crafts which can be used when special occasions arise and often real vocational training supersedes these more simple procedures.

ADJUSTMENTS TO INDIVIDUAL NEEDS

The activity necessary to carry on any of these crafts may not necessarily be that which is desired for the patient. In adapting the work to the individual needs, various adjustments must be made. For example, when shoulder motion is indicated, the work is elevated from time to time as the joints become more flexible. The seat level may also



Group activity has recreational as well as therapeutic value

be adjusted in leg work. When elbow extension is required, the shuttle of a hand loom may be made longer to insure the greatest amount of extension while weaving. If the patient's hand is unable to grasp a normal-sized handle of a chisel, beeswax or some other plastic material is molded to the hand to make possible equal use of all the fingers.

Grading of the strength necessary in operating the various contrivances may be accomplished in many ways. On

looms, elastics of increasing size are attached to the beater and treadles. In jig-sawing, the thickness of the wood may be increased or harder wood may be used. The application of friction to the wheel may produce the same effect. In any pedal work the strapping of the feet may increase the range of motion. The patients understand the reasons for these adjustments which make the work more difficult, and cooperate fully. When the patient is working in a group, there is



Printing press aids shoulder flexion, elbow extension, and wrist dorsiflexion



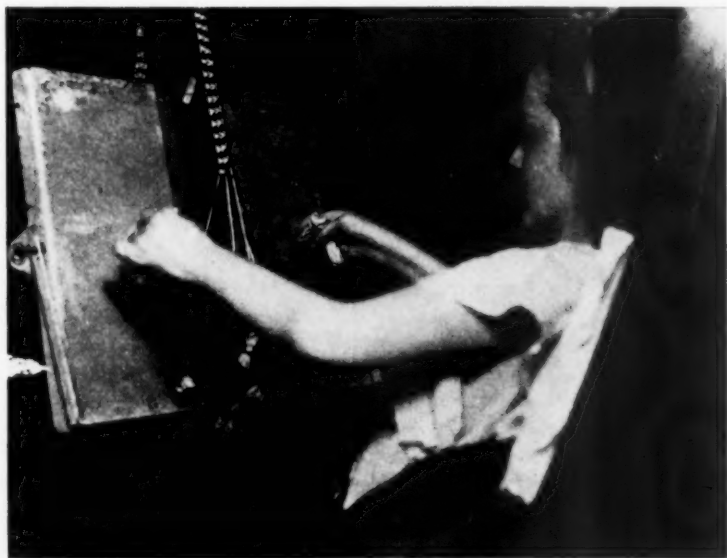
Foot-power lathe—for grasp, ankle dorsiflexion, pronation, or supination of forearm

an added stimulus in observing the working methods and progress of the other patients.

Throughout the work periods, which are part of the routine treatment for chronic arthritis, the occupational therapist should be constantly present. She must watch for signs of fatigue, observe any tendency on the part of the patient to work in a cramped or strained position, and encourage the use of correct posture as well as the maximum function of the limbs.

We have found that the monthly measurement of all joint motion helps the patient to continue with a certain kind of therapy with less mental resistance and often gives the therapist the first indication of fatigue, or of a need of change in work or method. The graphs are a valuable part of our permanent records.

The importance of complete understanding between the physician and the occupational therapist should be emphasized. Much harm can be done by the choice of the wrong work at the wrong time and done in the wrong way. When ordered and carried out concisely, occupational therapy can be a most valuable adjunct to recovery from arthritis.



Knotting—for shoulder flexion, elbow extension, and finger strength

Physical Therapy in Arthritis

By LORING T. SWAIM, M.D.

A description of physical therapy procedure employed in the treatment of chronic arthritis

THE IMPORTANCE of physical therapy in the treatment of chronic arthritis cannot be overestimated. Without the assistance of procedures of this sort, the physician would be severely handicapped in re-establishing function in the diseased joints. At the Robert B. Brigham Hospital, physiotherapeutic measures begin at the start of the treatment and continue in the all important follow-up clinic. These measures range from a direct therapy of the acutely inflamed joints to a general supervision of the body mechanics of the patient as a whole. The permanent rehabilitation of the patient is the primary object.

REST THERAPY

During convalescence, as well as in the acute stage of the disease, rest is an essential aid in the treatment of chronic arthritis. Simply lying in bed is not always restful and may be harmful to the arthritic. To obtain the maximum benefit from rest the patient is taught how to do it correctly. While he is lying on his back, a pillow is placed under the shoulders from the lower ribs to the neck. This causes the chest to expand and pulls the abdomen up. Painful joints are supported by plaster shells to allow the patient to relax. When the shoulders and arms are not severely involved, benefit may be obtained by lying part of the time in the prone position. The pillow is then placed under the abdomen allowing the ribs and abdominal viscera to drop forward.

It has been our custom, as part of the routine treatment, to have patients assume each of these positions for one

half hour three times a day after meals. The changes in circulation undoubtedly improve the digestive processes at these times. At night the patients are able to sleep more soundly if they wear their supporting plaster shells.

TYPES OF EXERCISE

Faulty posture, which is so common in arthritics, produces abnormal strain on weight-bearing joints and actually leads to increased pain and deformity. Postural exercises are given, first in the lying position and then, as the acuteness of the joints subsides, in the sitting and standing positions. These exercises consist of four simple procedures. The first two are for localized breathing, one for the upper and one for the lower chest and diaphragm. The next is an upward stretching of the ribs alternately from side to side. The fourth is the combined contraction of the lower abdominal and gluteal muscles to bring about a pelvic tilt.

As a preliminary measure for exercising the affected joints, the patient is taught to "set" or contract the adjacent muscles. This is carried on even when the joints are supported by solid casts, and it prevents muscle atrophy to a large degree. By thus retaining the muscle tone, the patient is ready to start active exercises when the soreness diminishes. Active exercises consist of utilizing the free range of motion along the lines of least resistance, in one joint at a time. The physical therapist guides the motions and often applies manual traction to avoid harmful friction between the joint surfaces.

All joints are exercised in a lying position except the knees, which are done with the patient sitting on the side of the bed. Elastic supporting cuffs are often

used to carry the weight of the limb and to eliminate friction with the bed. Underwater exercises are frequently used, especially in postoperative cases, in order to take advantage of the buoyancy of the water in reducing muscle strain and allowing greater ranges of motion. Before active exercises, it is often helpful to stimulate circulation by the use of heat.

APPLICATION OF HEAT

The primary object of heat is to increase circulation. We find that application of moist heat in the form of hot fomentations is as effective as the more complicated heat-producing appliances. It is advantageous because it is inexpensive and can be continued in the home. These fomentations are given three times a day when the joints are acutely inflamed.

Paraffin wax is also used, chiefly on the hands, as a means of retaining heat and producing perspiration. The hands are dipped into a pail of wax daily, thereby forming a glove which stays warm for about one-half hour. The paraffin bath is used at just melting temperature. As soon as the surface of the paraffin has cooled down to form a slight scum, it is ready to be used; or the hand may be dipped in the paraffin in the process of melting, when there is still a small amount of unmelted wax in the center. Paraffin never burns the hand at any temperature. In heating the substance, it is very important not to have it over an open flame, because of its inflammability. It should be

heated in a double boiler or on a hot radiator and should never be left on the stove unwatched. The paraffin may be used again and again by simply returning the wax glove from the hand, after it has been removed. There is danger of fire if the paraffin is allowed to get overhot.

Massage is another means of increasing the circulation and is very beneficial, but it must not be used on inflamed joints.

Steam baths are given when desired, since we find that hot vapor is less exhausting to the patient than the hot, dry baker; both increase the peripheral circulation and produce sweating, which is the primary object. A cold shower following the steam bath has a bracing effect.

In following the results of physiotherapeutic procedures, a complete photographic record is helpful. These photographs, taken at regular intervals, include posture pictures, pictures of visible deformities of joints, and composite pictures showing limitation of joint motion. Measurements of joint motion are also recorded numerically on graphs at regular intervals.

Rest and exercises must be checked periodically and altered to meet the changing needs of the patient.

It is to be emphasized that lasting results can be obtained only by constant supervision in the clinic after discharge from the hospital and by close coöperation between the physical therapists and the physicians.

*T*HERE is no time like spring,
When life's alive in everything,
Before new nestlings sing,
Before cleft swallows speed their journey back
Along the trackless track.

Christian G. Rossetti—Spring.

The Merit System Applied to Nursing

By MARION W. SHEAHAN, R.N.

A discussion of the selection and placement of public health nurses under the merit system from the point of view of the nurse administrator

THE SUBJECT of a merit system as it relates to nursing in public employment opens a new field of thought in nursing administration. The suggestions offered in this article are therefore not authoritative and are presented only as a starting point for further study and experiment. Of course every nurse administrator will need to review and keep abreast of current developments in the field of personnel management both in private and public employment. Armed with a reasonably broad knowledge of the experience of progressive organizations, she may begin to work out her own problems.

Since the titles used in the various states for comparable services are so varied, the term *civil service agency* will be used in this article to indicate a centralized civil service personnel agency, and the term *health department* will be used to indicate the administrative agency responsible for the nursing service.

PERSONNEL TECHNIQUES

The first approach to the problem may well be the assembling of all the written or unwritten personnel policies, plans and activities which affect the employment of persons on the nursing staff. Various questions may then be considered in relation to each other, as for example: methods for selection of staff; introduction to work; promotion opportunities; provisions for supervision; educational privileges; health and safety measures; adjustments to

handle grievances; policies in regard to discipline, discharge, transfers, vacations, sick leaves, and absences due to death and illness in the family; and security through compensation and pension plans. The practices in regard to these subjects may be studied in relation to their adequacy as policies and their effectiveness in facilitating good administration.

A knowledge of the similar practices in contemporary agencies of good standing will be useful for comparison. If needed, a master plan may then be drafted which will more nearly approximate adequate personnel administration and which will be useful as a guide toward sustained improvement. It may be found that some of the items can be translated into practice with little or no delay because they are within the control of the nursing administrator herself or of the state agency to which she belongs; still others will provide long-range objectives to be accomplished through still further plans to bring them about.

DEFINING THE JOB

The job content will determine the definition of the attributes of the person who can be expected to perform the work satisfactorily. We have but to look around in many offices to note the waste which occurs when the person seems not to fit the job.

Within certain limits, jobs may be made for employees who have earned such a consideration, but in general the

jobs must be defined to carry out the objectives of the agency. This makes clear the necessity for writing job specifications as a starting point in selecting staff.

The purposes for the creation of each job (or group of jobs) will be defined by the administration and the job will be placed in the organization setup according to lines of established authority. It will next be analyzed to know the details and skills it involves. It will then be classified according to established categories of service.

For example, in New York State before July 1932, all public health nurses below the grade of consultant were classified as supervising nurses. An analysis of each person's job led to the establishment of four classes or categories of nursing service: general public health nurses, orthopedic public health nurses, supervising public health nurses, and consultant public health nurses. The development of the service since that time has led to a new classification, district supervising public health nurse. Further consideration of job content is now under way and appears to be leading to a reclassification of the title, supervising public health nurse, to the more definitive title of assistant district supervising public health nurse.*

A word of warning should be given against the well known habit of writing the qualifications around the person whom the administrator wishes for the job. The temptation to do so is great and is usually motivated by anxiety to assure the right selection rather than trust to competition. At best, such compromises with scientific civil personnel management are of transient value, and each one perpetrated is a participation in the very practice which the merit system is intended to discourage. A

working knowledge of the principles of personnel selection should be the safeguard against such practice.

Progressive civil service departments will develop forms for the administrative officer to use in assembling information about the proposed job. This information is needed in handling the job through all the various steps—classification, testing the applicants, certification of the list of eligible candidates, and finally through probation to the permanent appointment of the worker selected. The nurse administrator is responsible for submitting accurate and descriptive information on the required form, along with such suggestions as she may wish to make. If no such forms are provided, the administrator may benefit from a study of standard forms used by other agencies, utilizing them as guides in assembling her evidence to support requests directed to the civil service agency.

PROFESSIONAL GROUPS CAN HELP

The opportunity of a professional organization to influence good practice should be noted. A committee on civil service problems appointed by the New York State Nurses' Association is studying all the nursing services conducted by their state. The committee has had in its membership an expert employed by the State Department of Civil Service. Through interviews, surveys, and the experience of committee members, it has assembled a concise statement of duties for each class of service and has suggested suitable professional qualifications for each class. This statement was sent to the Department of Civil Service for its consideration.

The Classification Division of the Department of Civil Service invited the director of the Division of Public Health Nursing of the State Department of Health to review the statement with them. Suggestions were made to be returned to the professional committee for

* The basic title, public health nurse, is carried through all of these titles to differentiate this group from hospital nurses, of whom there are many in the state service.

its consideration. Out of this joining of effort will evolve a set of qualifications which should be satisfactory to the two state agencies concerned and which will be in keeping with the standards thought desirable by the profession.

The American Nurses' Association has suggested that each state establish such a committee. The opportunity which well organized and ethically conducted professional groups have to assist in establishing and maintaining professional standards in public service against the forces which would reduce or eliminate them should not be overlooked. Intelligent committees of the professions, speaking with a knowledge of the subject, have great potential strength as organized citizens as well as professional workers, to influence reform where it is needed.

RECRUITING CANDIDATES

When the job has been defined and the qualifications of the nurse prescribed, desirable candidates must be encouraged to apply. An effective civil service department will be active in publicizing the examinations it plans. But such publicity in itself, no matter how far-reaching, will not attract well prepared, progressive nurses. It is the obligation of the nursing division so to develop and interpret its program that becoming a part of its personnel gives prestige to the type of worker it wishes to attract. Building a reputation for the agency is a constant process inextricably bound up with the spirit and quality of work performed day by day, year by year.

The channels through which persons will become interested in the nursing program include published articles; staff participation in programs; reports; interviews; active participation of staff members in professional associations; and contacts of the staff with educational institutions, vocational bureaus, and other nursing agencies, and with in-

fluential professional and lay people. The influence of the existing staff and their friends and relatives in attracting or repelling desirable candidates cannot be minimized.

Every intelligent potential candidate will want sufficient information about the job to determine whether the position is worth competing for. The nurse administrator can aid the civil service agency by presenting data pertinent to the position. These include a concise description of the job, clear-cut qualifications, title, salary available at appointment, salary range, promotional opportunities, number of appointments expected, last date for filing application, place of examinations, comparative weights given to the various parts of the examination, and such items as the requirement for driving licenses and travel involved in job. If by chance the civil service agency fails to assemble such pertinent data, it is within the province of the nursing administrator to draft a statement supplying this information to institutions or individuals who are addressed for recruiting purposes.

Some handicaps to recruitment cannot be ignored. Limitation of competition to American citizens apparently so generally meets with public approval, that it appears wise to accept it and direct our efforts toward the correction of other handicaps. Chief among these is the demand for state or local residence as a prerequisite to examination. An appreciation of the reasons for such provincialism will help to combat it. There have been enough job failures resulting from this particular limitation to testify that the advantage of choosing a home candidate regardless of qualifications is lost. While this practice is tied in with the patronage policies of our political organizations, its social roots are deep. Many intelligent citizens encourage and accept such practices. The fact that so many small communities have streets

and squares bearing the names of the resident families who contributed to their histories is evidence of the strength of the heartstrings which bind us to provincial thinking.

These social and political limitations will not yield to quick remedies. The final solution is the slow process of public education. The immediate aids are:

1. The establishment by the state authority of minimum qualifications for all public health nurses paid from public funds.

2. Securing the acceptance of these standards by local jurisdictions.

3. Assistance to the local civil service and service agencies in interpreting the standards to their public, in recruiting applicants, and in establishing employment standards to aid in selection. These aids from the state agency may be initiated within itself or by one of its own local units, depending upon the point wherein lies the greatest leadership.

EXAMINATION OF APPLICANTS

The most frequent steps utilized in the examining process are (1) evaluation of experience and education (2) formal testing (3) rating. Application forms are universally used to assemble identifying data regarding the applicant, information to determine whether she meets the announced requirements for the position, and information regarding her education and experience which will help the examiner in comparative rating. Later this information will be an aid to the appointing officer in making a selection within the limits of the civil service rules.

The civil service personnel agency usually adopts some application form; the nursing agency, too, needs one to use as an aid to recruiting. It is within the province of the nursing agency to suggest changes in the civil service form or to suggest a supplementary form which will give information beyond that required by the civil service agency. This will be advisable especially when the civil service form is a general one used for all types of positions.

Application forms are so widely used that their adequacy deserves attention. In a study made of 84,000 civil service applications, more than 50,000 had to be returned for correction.* This study led to the formulation of the following principles which should be considered in the formulation of application forms:

1. Each question should refer to a single specific point. The presentation of two or more questions on a single line should be avoided.

2. The questions should be worded as clearly and concisely as possible.

3. Questions should be phrased so as to require brief, direct answers. Wherever possible they should be capable of being answered by either "yes" or "no." If more is required the space provided should be adequate.

4. It is desirable to place specific instructions as to how to answer each question under each answer line.

5. It is advantageous to arrange questions in parallel columns, with answer lines to the right of each. This not only makes it less easy for an applicant to omit or skip a question, but also facilitates the checking of the blanks by the employing agency.

6. The type employed should be large and easily readable and the use of heavy rules between questions avoided.

7. The minimum requirements for the position should be printed in bold type at the top of the blank.*

REVIEWING APPLICATIONS

All applications should be carefully reviewed to determine whether the applicants meet the requirements outlined in the announcement of the examination. This will call attention to the wisdom of giving care to the preparation of the announcement so that it will describe the requirements accurately. The nursing administrator is usually responsible for drafting the statement relating to the professional requirements, so she should review it for its adequacy in relation to this evaluation process. Applicants who do not meet all the requirements should be eliminated at this point.

* Mosher, William E. and Kingsley, J. Donald. *Public Personnel Administration*. Harper and Brothers, 1936, pp. 133-134.

The applications of these candidates who pass the subsequent formal tests should be reviewed again after the examination for the rating of education and experience. Statements should be verified and records of past performance secured. Since the greater proportion of the total score is usually allowed for experience and education—or 6 or 7 points out of 10—this part of testing deserves more consideration than it usually receives. The translation of an estimate of the value of experience into a score is no easy task. A neutral professional person with a knowledge of relative values of professional experiences should make the evaluation on a qualitative as well as a quantitative basis. If the effort to secure such professional evaluation fails, the nonprofessional examiner in the civil service agency will usually be glad to accept a guide as an aid in evaluation.

A chart may be prepared by the agency employing the nurses, showing the types of experience that nurses may be expected to submit. Such a chart can be arranged to show the value of each type of experience as preparation for the position for which the candidates are being examined. A companion chart may be prepared of the agencies in the recruiting area in which such nursing experience may have been obtained. The scope of the programs of these agencies and the supervision offered their staffs may be indicated to estimate the relative values of the experience they offer. Each new experience or agency presented to the examiner may be referred to the employing agency for evaluation as a means of keeping the chart comprehensive and up to date.

A standing committee of the appropriate professional associations may well undertake such assistance. The nursing administrator or the committee may indicate readiness to assist the civil service examiner with problem applications. Other ways may be thought of

to secure the best evaluation possible, until such time as the civil service agency can arrange for professional reviewing.

FORMAL TESTING

Formal tests are designed to measure the general intelligence, abilities, skills, special aptitudes, and personalities of candidates, and at their best to indicate potentialities for growth and development. This latter purpose is in keeping with the emphasis on career service. Recent years have produced many special tests for the above purposes which may be found useful if handled by persons who understand them. Few of them—especially those which relate to personal characteristics—have been developed to the point that they are safe instruments for inexperienced examiners. As important as these personal qualities are, they are the most difficult to evaluate through testing methods. Oral examinations are designed for such a purpose but they too require special skills in interpreting observations which are essentially subjective.

The expense of experts in this field will often prevent their use, even where their value is appreciated. Because of this fact the examination of nurses, except for top positions, will usually be limited to a test of their professional knowledge and skills. The nursing director concerned should be expected to assist the civil service agency in this respect.

An analysis of the professional knowledge of a group of recent appointees will help to determine whether there are deficiencies which are not justifiable and which might have been determined through tests. Specific health information as well as the candidate's comprehension of the entire health and nursing program may thus be tested. The use of the English language might well be given consideration in tests, although it usually is not.

PROFESSIONAL EXAMINERS

Examination questions should be prepared and the papers rated by nurses whose knowledge of public health nursing is respected. Many civil service agencies employ such special examiners and pay a specified hourly rate for service. Where no funds are available for this purpose, the nursing agency might well work for some plan to secure such professional aid. The health department may be able to pay for this help, offering it to the civil service agency. If no other way presents itself, a carefully selected professional committee might undertake such service without compensation. In fairness to the candidates, the civil service agency requires that anyone writing tests be in a position of neutrality. The members of the nursing agency expecting to make appointments are therefore disqualified.

RATING

The final rating of each candidate will be the total of the scores obtained in the various parts of the examining process according to the relative weight assigned to each test. The nursing administrator should suggest which of the tests used are most useful in evaluating the fitness of nurses and which therefore should be assigned the greatest weight. No candidate, no matter how well qualified, is given consideration if a passing mark is not secured in the formal tests.

CERTIFICATION

From the list of candidates who are certified, in the order of their rating, as eligible for appointment, the nursing director must make the best selection. Civil service rules will narrow selection either to the first on the list, one of four or five, or one of three—the latter being the most common.

Given a choice, it will be worth the time and effort and is within the authority of the department concerned to

plan its own placement policies. No assistance in selection should be overlooked. The civil service application and the examination papers of eligible candidates should be available for review.

A further investigation of credentials and employment records should be made if they are not already available through the civil service agency. Correspondence with the candidate will give some indication of her ability to write grammatically, legibly, neatly, and courteously, and to express her meaning in written words. A tentative choice can be made on the above bases, especially if interviewing involves expense for the candidate or the agency.

One or more interviews with the candidate are important, however, conducted if possible by two or three of the administrative group of the nursing agency. A simple form to follow in recording observations is suggested by Mosher and Kingsley in their book on *Public Personnel Administration*.^{*} It should be recognized that an interview is a mutual opportunity allowing both the candidate and the employer to judge each other.

PROBATION

A period of probation, usually three to six months, is allowed before the appointment becomes final. This is the last step in the testing process. A comprehensive introduction to the work, followed by graded assignments as the nurse becomes familiar with her work, should be planned. The best supervision the agency affords should be offered. An objective activity report should be kept. The final judgment should be reviewed with the director, the supervisor, and the appointee. A

^{*} Mosher, William E. and Kingsley, J. Donald. *Public Personnel Administration*. Harper and Brothers, 1936, pp. 132-134. The study referred to was made by Dr. L. J. O'Rourke and described in the Annual Reports of Federal Civil Service Commission for 1928, 1929, and 1931.

decision based on evidence as objective as possible should be reached. Subjective evidences should be checked by two or three individuals if possible. A probationary appointee under most civil service rules may be dropped without the presentation of supporting evidence to the civil service agency. In fairness to the individual nurse as well as to the service, nothing should interfere with as accurate a judgment as it is possible to attain.

GROWTH IN SERVICE

It is not within the scope of this article to discuss the continuity of the merit system as it continues to affect the nurse who has reached a permanent status. Every person of supervisory level shares this responsibility. Upon the understanding and skill of these leaders, from the top down through the

line, will depend the career opportunities of the nurses who form the organization. The ultimate success of the merit system in assuring an effective public service for the community will depend on the application of its principles to the continuous service of the agency.

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American Management Association. *Handbook of Business Administration*. W. J. Donald, editor in chief, McGraw-Hill Book Company, New York, 1931. Section on Personnel Management.

Summer Courses for Public Health Nurses

SUMMER COURSES IN COLLEGES AND UNIVERSITIES WHOSE PUBLIC HEALTH NURSING CURRICULA HAVE BEEN APPROVED BY THE NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

For students meeting the admission requirements, this work may usually be counted toward a degree.

California

Berkeley. *University of California.* Intersession, May 20-June 28; summer session, July 1-August 9. The following courses are to be conducted as an institute of three weeks' duration (July 1-July 21) for graduate nurses who are registered in the State of California: public health aspects of maternal and infant hygiene—Louise Zetzsche, director of maternity service, Visiting Nurse Association, Denver, Colorado; medical problems in maternal and infant hygiene—Ellen S. Stadtmuller, chief, Bureau of Child Hygiene, State Department of Public Health, California; group discussions—Ruth W. Hay, assistant professor of nursing education, University of California, Berkeley, and Margaret Blee, instructor in nursing education, University of California, Berkeley. Three units of credit will be given for attendance at the institute. Nonresident graduate nurses who are registered in their respective states may be admitted upon the consent of Miss Hay. Other courses in psychology, mental hygiene, sociology, economics, child development, and school health will be offered during intersession and regular session.

For further information write to Ruth W. Hay, Division of Nursing Education.

Los Angeles. *University of California.* July 1-August 9. Courses in public health nursing, family case work as related to public health nursing, principles and methods of teaching

applied to home hygiene, public health, school health, child development, nutrition, educational psychology, care of dependents, social institutions.

For further information write to dean of the summer session, 405 Hilgard Avenue.

District of Columbia

Washington. The Catholic University of America. Summer session, June 28-August 10. Courses in public health nursing, maternal and child hygiene, preventable diseases and public health, nutrition. Other courses required in the public health nursing program in the following fields: sociology, psychology, public speaking, and child study. Related courses in economics, philosophy including ethics, and political science.

For further information write to Lucia Sweeton, acting director of public health nursing, The School of Nursing Education.

Hawaii

Honolulu. University of Hawaii. June 24-August 23. Courses in supervision in nursing and the teaching of health. Guest instructor, Hedwig Toelle.

For further information write to Theodora A. Floyd, director, Public Health Nursing.

Illinois

Chicago. The University of Chicago. First term, June 19-July 19; second term, July 22-August 23. Students may be admitted to the following courses at the beginning of either term: special fields in public health nursing, public health. Students may be admitted to the following courses at the beginning of the first term only: principles of public health nursing, supervision, organization and administration in public health nursing. These courses extend throughout both terms. The teaching of health will be given as a half course in the second term. A limited number of qualified, graduate nurses will be admitted to the Workshop for college instructors to be held during the second term of the summer quarter. For further information write Nellie X. Hawkinson, Nursing Education, The University of Chicago.

Indiana

Bloomington. Indiana University. June 11-August 7. Courses will be given in principles of public health nursing, education, anatomy, English, home economics, sociology, and psychology. There will be a limited amount of supervised practice teaching in the field of health and public health nursing for those who have made advanced application.

For further information write Dean H. L. Smith, director of summer session.

Massachusetts

Boston. Simmons College. July 1-August 9. Courses in principles of teaching, principles of public health nursing, public health nursing in schools, social hygiene (July 22-August 9), evaluation and teaching of nursing procedures, principles of supervision (July 1-July 19), psychology for nurses. Guest instructors, Augusta Patton, Gertrude E. Cromwell, Nels Nelson, M.D., and Harriet Frost.

For further information write to the director, School of Nursing, 300 The Fenway.

Michigan

Ann Arbor. University of Michigan. June 24-August 2. Courses in principles, special fields, supervision, organization, and administration of public health nursing—guest instructor, Amy MacOwan. Courses also in public health, child hygiene, school health programs, nutrition, health education, control of tuberculosis, sex education, eye hygiene, mental hygiene, physiologic hygiene, communicable diseases and epidemiology, public health statistics, public health law and administration, sanitation, industrial hygiene, race hygiene, public health aspects of social case work. English, psychology, sociology, and other academic courses may be taken during the eight weeks' summer session which continues until August 16. For further information, write to Ella E. McNeil, director of public health nursing.

Detroit. Wayne University. June 24-August 3. Courses in English, psychology, and sociology required for the public health nursing certificate.

For further information, write to Louise Knapp, director of Nursing Department.

Minnesota

Minneapolis. University of Minnesota. June 17-July 26. Courses in tuberculosis and its control, mental hygiene, principles of public health nursing, field work with family health

agency, supervision in public health nursing, advanced problems in public health nursing, biometric principles. July 29-August 30. Courses in special methods and supervised practice in health teaching, elements of preventive medicine and public health, maternal and child hygiene, field work with family health agency, public health administration, environmental sanitation.

For further information, write to Margaret Arnstein, director, Course in Public Health Nursing.

New York

Brooklyn. St. John's University, Teachers College. July 5-August 9. Courses in health education, psychology for teachers, principles of high school teaching, history of education, English, introduction to sociology, public speaking.

For further information write to Philomena Supper, director, Nursing Education Department, 75 Lewis Avenue.

New York. Teachers College, Columbia University. July 8-August 16. Courses in public health nursing, public health administration, psychology, sociology, parent education, guidance, history, English, and science.

For further information, write to secretary of Teachers College, Columbia University.

New York. New York University, Washington Square. Intersession, June 4-28. Principles and methods of teaching in nursing education. Summer session, July 2-19 and July 22-August 9. Courses in public health nursing, school nursing, teaching of home nursing and child care, public health administration, psychology, other related fields. Lake Sebago, July 2-August 9. Courses in orthopedics.

For further information, write to Dr. Helen C. Manzer, School of Education.

Syracuse. Syracuse University. July 1-August 9. Courses in principles of public health nursing, maternity and child hygiene, special fields in public health nursing, case studies in public health nursing, preventable diseases, nutrition, psychology, related courses in education and sociology.

For further information, write to Ellen L. Buell, director, Department of Public Health Nursing.

Ohio

Cleveland. Western Reserve University. June 18-July 26. Courses in principles of public health nursing and principles of orthopsychiatry, required for the eleven months' program in public health nursing.

For further information, write to director of Summer Session, School of Nursing.

Oregon

Portland, University of Oregon. June 17-August 30. Courses in principles, organization, supervision, and field work in public health nursing; in public health and communicable disease, principles and field work in social case work for public health nurses, nutrition, child welfare, public health, vital statistics, community organization. Refresher program for nurses June 17-July 27.

For further information write to Elnora Thomson, director, Department of Nursing Education.

Pennsylvania

Pittsburgh. Duquesne University. July 1-August 9. Courses in principles of public health nursing, public health nursing in maternity, infancy and preschool service, school nursing, sociology, psychology, related courses in education. Field practice in public health nursing.

For further information, write to Clara B. Rue, director, Course in Public Health Nursing.

Philadelphia. University of Pennsylvania. June 25-August 6. Courses in special phases of public health nursing, school nursing, social case work principles. General academic courses in the sciences, sociology, and education.

For further information, write to Katharine Tucker, director, Department of Nursing Education.

Tennessee

Nashville. George Peabody College for Teachers. June 10-August 23. Courses in public health nursing, school nursing, health and food, public health administration, methods in teaching home hygiene, methods in school health education, introduction to sociology, social case work.

For further information, write to Aurelia B. Potts, George Peabody College for Teachers.

Washington

Seattle. University of Washington. First term, June 17-July 17; second term, July 18-August 16. Courses are offered in elementary and advanced public health nursing, health

education, mental hygiene, epidemiology, hospital supervision and teaching. Courses are also offered in allied fields such as sociology, education, psychology, and bacteriology. For further information, write to Mrs. Elizabeth S. Soule, director, School of Nursing Education, University of Washington.

OTHER COURSES IN CURRICULA WHICH HAVE NOT BEEN EVALUATED BY THE N.O.P.H.N.

Colorado

Greeley. Colorado State College of Education. June 17-July 12, courses in nursing education. July 1-August 10, courses in health education, social hygiene, community health. June 17-August 10, work shop on educational problems for teachers and administrators. July 5 and 6, institute: guidance in nursing education. For further information write to Phoebe M. Kandel, director, Summer School Nursing Education Program.

Illinois

Chicago. Loyola University School of Medicine. June 24-August 3. Courses in principles, special fields, organization, and administration of public health nursing; in methods and materials in health education, public health statistics, principles of social case work, school health problems, nutrition, sociology, hygiene, epidemiology, mental hygiene, public health law; child welfare, public health, vital statistics.

For further information, write to Dr. Earl E. Kleinschmidt, director, Department of Preventive Medicine, Public Health and Bacteriology.

Chicago. Northwestern University Medical School. June 10-August 31. Special summer course in physical therapy designed for physical therapists who wish to review fundamental subjects. Lectures and demonstrations in human anatomy and physiology and pathology. For further information, write to Dr. John S. Coulter, Department of Physical Therapy, Northwestern University Medical School, 303 East Chicago Avenue.

Massachusetts

Boston. Harvard University. June 18-August 2. An intensive seven weeks' course in physiotherapy open to nurses.

For further information write to the assistant dean, Courses for Graduates, Harvard Medical School.

Cambridge. Massachusetts Institute of Technology. July 1-August 21. Offers the first session of a graduate program of four summers in public health, school health, and health education, leading to a certificate in public health.

For further information, write to Professor C. E. Turner, Department of Biology and Public Health.

New York

Buffalo. The University of Buffalo. July 1-August 10. Courses in hydrotherapy, educational psychology, preparation for teaching in secondary schools, field of social work; in mental, social, and vocational adjustment of the handicapped. Seminar in mental hygiene and psychoanalysis.

For further information, write to Mrs. Anne Sengbusch, educational adviser to nurses, Medical School, 24 High Street.

Pennsylvania

Leetsdale. D. T. Watson School of Physiotherapy, affiliated with University of Pittsburgh School of Medicine. July 1-August 9. Six weeks' course in basic physiotherapy and orthopedics.

For information, write to Jessie Wright, M.D., Director.

State College. Pennsylvania State College. July 1-August 9 and August 12-30. Mildred Coyle, R.N., director of school nurses, Easton, Pennsylvania. Courses in health education, special problems for school nurses in health service. Other courses offered are: educational and vocational guidance, principles and procedures in family and school relationships; abnormal psychology, psychological factors in marital and home adjustments, mental hygiene, educational psychology.

For further information, write to P. C. Weaver, assistant director of Summer Sessions.

Nutrition as It Relates to the Eye

By ARTHUR M. YUDKIN, M.D.

The health of the eye as well as the general health of the body is affected by diet deficiencies and by faulty nutrition

THE DEVELOPMENT of the science of nutrition and its application to human welfare is of practical value to the medical profession and its allied groups. For years students of nutrition have sought for an adequate diet which would maintain normal growth and good health in laboratory animals.

From the time of Hippocrates to the opening of the last century, it was believed that the value of every food depended upon the presence of a single universal nutrient substance which was absorbed by the various organs and tissues as the food passed through the body. This idea was eventually dispelled when investigators found by chemical and biological studies that food substances actually consisted of at least three principles—proteins, carbohydrates, and fats. It soon became evident that certain mineral elements were also necessary in the ordinary diet.

With the accumulation of data from animal feeding experiments, it was observed that the quality of a ration could not be accurately predicted on the basis of its chemical composition. It was also demonstrated by chemical studies that proteins from different sources yielded on digestion various types of amino acids. Some nutritionists conducted experiments with mixtures of natural feeding stuffs, and others used the by-products of the slaughter house, but their results were not of a nature which could lead to a very complete understanding of the problem. A new method of approach to the study of the nutritive

requirements of the body and the properties of the individual foodstuffs was necessary.

Inspired by the previous work in the field of nutrition, Mendel¹ and his co-workers and McCollom² with his demonstrated that a well balanced diet including the vitamins was necessary to maintain good health and normal growth in laboratory animals. This discovery was in the main responsible for the beginning of the present vitamin era. It also provided a basis on which to explain the peculiar virtues of certain foods for specific purposes; namely, why fresh vegetables and citrus fruits are beneficial in the treatment of scurvy; cod-liver oil in rickets; liver in night blindness; and barley—as a substitute for polished rice—in beriberi.

The most striking feature in the development of the science of nutrition is the fact that in many instances the discoveries were made by men trained primarily in the basic physical and biological sciences. Their studies have resulted in the discovery of at least ten different vitamins and several mineral elements which are essential for the normal functioning of the organism.

NUTRITIVE DEFICIENCY AFFECTS EYE

It was apparent from these early investigations that the ocular tissue may become involved when the diet lacks certain ingredients. In 1909, Knapp³ restricted rats to a diet of purified food substances consisting of proteins, carbohydrates, fats, and mineral salts, and described a severe conjunctivitis which

developed as the nutrition of his animals failed. In 1913, Osborne and Mendel⁴ attributed the eye disturbance which they produced in the albino rat to a type of nutritive deficiency exemplified in the form of an infectious eye disease, which was speedily alleviated by the introduction of butterfat into the diet.

McCollum and Simmonds⁵ had repeatedly observed the development of this peculiar form of ophthalmia in animals subsisting upon their experimental diets. They found it to occur only in those animals whose diets were faulty in content of vitamin A. McCollum and Simmonds correlated these observations on rats with those reported in humans by Bloch⁶ and by Mori⁷ and came to the conclusion that the xerophthalmia (dryness of the bulbar conjunctiva) or keratomalacia (softening of the cornea) produced experimentally in animals resembled the condition these other authors have reported in man. On this evidence they formulated the view that this type of xerophthalmia was a deficiency disease in the same sense as beriberi, and that it was due specifically to the lack of vitamin A.

A survey of old records reveals the frequent association of ocular diseases with famines caused by drought, poor crops, and war. Ophthalmologists have repeatedly referred to night blindness, xerophthalmia, corneal lesions, and several forms of chorioretinitis as due to faulty nutrition. These eye disturbances in man, to be sure, result from conditions so complicated that it is not possible without further evidence to attribute all of them to lack of a single vitamin. Gross vitamin deficiency in man appears to have been somewhat more common in Europe and Asia than in this country.

However, recent studies made in the United States would seem to indicate the surprising prevalence of subclinical vitamin A deficiency, particularly among

children. The diagnosis is based on the assumption that individuals who show poor adaptation to the dark probably have a vitamin A deficiency. It is possible that these conditions are now more readily detected because of a better understanding of the subject and because of their similarity to some of the disturbances produced experimentally in the laboratory animal by deficient diets. Vitamin deficiencies occur at all ages and are not confined to the poor. They can and do occur even in prosperous communities.

EYE IS KEY TO BODY HEALTH

The question is frequently asked, why is the ophthalmologist in a position to determine the health of the individual? By his medical education and postgraduate training in ophthalmology he is equipped to interpret his observation of the ocular tissue. The eye is not only the organ of sight, but is part of the body; and many of its diseases are simply an expression of a general pathological state and can be properly understood only when considered in that true perspective.

When the interior of an eye is illuminated by an ophthalmoscope, the contained structures at once come into view in a manner impossible in any other part of the body. There, under direct observation, is the blood supply of the eye, and it is not difficult to appraise its character—whether there is present sclerosis of the vessels, hypertension, and other vascular degenerative changes. The quantity and quality of the pigment in the layers of the retina and choroid are helpful in deciding whether the person is a blond or a brunette, and also whether the ocular tissue is in a state of good health. There is also visible the entrance of the optic nerve, which is seen as a disc and forms a most conspicuous feature in the red background of the eye.

From an embryologic point of view,

the retina may be regarded as the extra-cranial portion of the cerebral cortex, and the stalk of the optic nerve as corresponding to the association fibres in the brain. Its sheaths are formed by prolongations of the cerebral meninges and its enclosed spaces continue directly with subdural and subarachnoid spaces around the brain. The arteries are terminal branches of the cerebral arteries and the venous blood is partially emptied in the cavernous sinus.

Since the tissues of the living eye are so intimately associated with the structures of the rest of the body, it is reasonable to assume that whatever takes place in the eye may also, under similar conditions, occur in other parts of the body. The old family doctor always examined the ocular tissue for signs of constitutional disturbance such as gastro-intestinal dysfunction, abnormal liver secretion, or increased body temperature. Much can still be learned by such observations.

OCULAR DISEASES OF MALNUTRITION

It is agreed that a well balanced diet is the source of all human energy and for that reason is the basis of the maintenance of life and the building of vital resistance of the body against disease. The absence of any one or more of the important energy-yielding substances, minerals, or vitamins from the diet leads to the development of a syndrome which is called a deficiency disease. Experimentally it has been shown that animals on deficiency diets in many instances develop ocular diseases.

Thus, if the animal is deprived of vitamin A it may develop night blindness, xerophthalmia, keratomalacia, and dystrophy of the lubricating glands of the eye. When lacking vitamin G, corneal lesions develop and the lens becomes cataractous. If the animal is deprived of vitamin C, hemorrhages frequently occur in the ocular tissue. If the sugars, lactose, galactose, and

xylose are given in quantities comprising more than 25 percent of the diet, cataracts develop. Many other examples of ocular disturbances due to malnutrition have been reported but they have not as yet been confirmed by other investigators.

It is apparent from a survey of the recent literature that many of the deficiency diseases, whether they are complete or incomplete, are accompanied by some form of visual disturbance. Spies⁸ and his co-workers have observed that more than 70 percent of the patients in the nutrition clinic who have frequent recurrences of pellagra, beriberi, and flavine deficiencies also have visual disturbances. Some of these symptoms are characteristic of vitamin A deficiency. Many of them have dry, burning eyes and on examination exhibit marked conjunctivitis, particularly in the conjunctiva of the lower lid. It is reasonable to conclude that ocular tissue may also be damaged when other parts of the body are involved in deficiency diseases.

ADAPTATION OF EYES TO THE DARK

It is evident from the early animal experimentation that there must be some relation between vitamin A deficiency and poor adaptation of the eyes to the dark. At first it was difficult to understand the part vitamin A played in the process until it was disclosed that the rate of regeneration of visual purple (purple pigment in the retinal rods) after its bleaching by a bright light in the living animals was less in the rats receiving the deficient diets than in the controls. Pathological changes were observed at the chorio-retinal junction of the eyes removed from these animals.

Recently Johnson⁹ observed that moderate vitamin A deficiency produces degenerative changes in the retina which are evidenced by abnormal staining reaction and extreme friability of the rod outer segments in the periphery and by

the complete degeneration of the rod outer segments in the fundus. It was shown that the fat extracted from normal retinae of several species is one of the richest sources of vitamin A substance. This finding suggested the possible relationship of vitamin A content of the retina to visual purple.

It was later demonstrated by Wald¹⁰ that vitamin A was necessary in the formation of visual purple in the retina. He modernized the ideas advanced by Kühne¹¹ on the formation of visual purple. Wald showed that in mammals, birds, and certain fishes, vitamin A unites in the retina with a protein to form visual purple. Under the influence of light, visual purple is changed to visual yellow, and a portion of the visual yellow reverts in the dark to visual purple; another portion undergoes decomposition into vitamin A and a protein. This process takes place continuously in the retina and the completeness of the conversion depends on the supply of vitamin A to the ocular tissue, which in turn is related to the supply in the entire body.

Until recently the variation of visual purple in dark-adapted eyes was attributed to changes in the rods alone, but Hecht¹² and his co-workers demonstrated that the cones likewise play a significant role in the visual cycle. They conclude from a study of persons afflicted with chronic liver disease that there is a true parallelism in the behavior of cones and rods in dark adaptation and its response to vitamin A therapy. Hecht reports that healthy individuals deprived of vitamin A show an almost immediate rise in the intensity level of their dark adaptation. After a week of deprivation, the intensity level is well above that found in a normal person and may be diagnosed with reasonable certainty. After four weeks of deprivation the intensity level of dark adaptation may be a hundred times as high as normal. The resumption of a normal

vitamin-supplemented diet does not produce a spectacular drop in the visual threshold but rather a slow return to normal, lasting several weeks.

OTHER CAUSES OF NIGHT BLINDNESS

All nutrition workers agree that a deficiency of vitamin A results in the loss of visual acuity in dimly lighted places. However, the reverse is not always true, for night blindness also occurs in diseases of the eye such as congenital total color blindness and congenital family hereditary hemeralopia.

It has been reported to be associated with malaria, gastro-intestinal disturbances, nephritis, diabetes, anæmia, cachexia, and some liver disturbances. A close scrutiny of these general disturbances may reveal an improper utilization of ingested vitamin A of the diet. Night blindness often accompanies poisoning caused by quinine, carbon bisulphite, alcohol, nicotine, adrenalin, and various poisonous gases employed in warfare. It is a symptom frequently associated with syphilitic chorioretinitis, disseminated choroiditis, retinitis pigmentosa, detachment of the retina, optic atrophy, optic neuritis, sympathetic ophthalmia, glaucoma, and progressive myopia, and in Oguchi's disease.

Some health workers and practitioners of medicine have concluded that poor dark adaptation is *prima-facie* evidence of a vitamin A deficiency in man and therefore that some of the automobile crashes at night are the result of a vitamin A deficiency. The writer cannot subscribe to this assumption for he believes that the lack of vitamin A in the body is only one of many factors responsible for poor dark adaptation. Not until the test now advocated for dark adaptation is improved and normals established can it be said that poor dark adaptation in nearly every case is a result of vitamin A deficiency. It is apparent that a blood test for vitamin A would be a step forward in checking

the visual apparatus now advocated.

END RESULTS OF VITAMIN A LACK

It is agreed that changes in the ocular tissue occur rather late in vitamin A deficiency. The epithelium of the conjunctiva, cornea, glands of the lids, and glands of lacrimation become atrophic. The destruction is followed by a differentiation of the new cells into a layer of epithelium that has lost its normal function. This process produces a dryness of the bulbar conjunctiva (xerophthalmia), altered secretion of the meibomian glands, and an abnormal lacrimal secretion so that tears can no longer act as a protective medium for the delicate corneal tissue.

The cornea becomes less sensitive; there is an irregular wrinkling of the bulbar conjunctiva, and patches of broken-down keratinized epithelium gather in the cul-de-sac and become adherent to the eyeball. The superficial tissue of the cornea is destroyed and ulceration sets in with a complete breaking down of the cornea, or keratomalacia. The impairment of vision follows and permanent blindness is the penalty for this extreme vitamin A deficiency of the ocular tissue. It is rather unusual to see this type of ocular lesion in this country but many of the earlier disturbances are seen.

CORNEAL LESIONS

Recently the writer described an ocular condition encountered in adults between the ages of 45 and 68 years. From all outward appearances these individuals seemed healthy, and a thorough physical examination did not reveal any manifestations of disease. A review of the patients' mode of living indicated that the ocular condition was accompanied by a loss of appetite, constipation, headache, and general malaise. Many of these patients had lost their teeth early in adult life. The first complaint was that of having something in

the eye and photophobia. The cornea appeared normal at first. Nevertheless, the eye was very painful. The patient noted no visible ocular disturbance.

When the eye was examined, there was a breaking down of the periphery of a portion of the cornea which was exposed in the palpebral fissure or in the area covered by the lower lid. There was very little if any congestion present. The cornea also stained with fluorescein. The lesion did not seem to improve with local treatment, and within a few days the broken-down area of the cornea appeared more extensive. The invaded cornea exhibited a shallow, excavated ulceration which frequently spread along the margin of the cornea and extended towards the margin of the pupil. An examination of this area with the slit lamp revealed a swollen, edematous corneal epithelium and a similar involvement of the substantia propria. The surrounding tissues showed considerable congestion. The corneal nerve fibres extending into the diseased area were very prominent.

In the early stages of this type of corneal lesion no definite inflammation of the deeper layers of the cornea and uveal tract could be detected. Often this form of corneal lesion is described as a catarrhal ulcer without any definite inflammation of the conjunctiva. In some instances the ulceration has a traumatic appearance but no history of injury can be elicited. Frequently when first seen the corneal lesion resembles that of marginal ulcer, indolent ulcer, or rodent ulcer. At this latter stage the aqueous humor reveals numerous floaters.

In the past, the treatment of this type of corneal lesion has been very unsatisfactory. It was suggested from experience in the laboratory with animals on deficiency diseases that this ocular condition might be nutritional in nature. Therefore, a number of these patients were given cod-liver oil in addition to

their regular diet. Some showed improvement in a short period of time while others did not respond. It was evident that some other factor was involved. From the history of the cases it appeared that the intestinal tract might be at fault. These patients were injected with vitamin B₁, (thiamin chloride) and were given large quantities of vitamin B complex before each meal in addition to the cod-liver oil. In the majority of these cases the constitutional disturbance and ocular lesion disappeared simultaneously. Although the ocular lesion cleared up with the supplement of cod-liver oil and vitamin B complex in the diet, we are not justified in claiming that the ocular lesion was due specifically to deficiency of vitamin A or vitamin B complex. We may, however, look at it as a multiple deficiency of some kind.

Medical authorities are now in accord that a well balanced diet is important in promoting good health. McLester¹³ points out that nutritive failure does not come solely from lack of vitamins but from deficiency of proteins and minerals as well; in certain of the lower animals it comes even from lack of fats; and it is not as a rule the expression of a single nutritive fault.

LESIONS OF THE CONJUNCTIVA

It is a known fact that phlyctenular keratoconjunctivitis was formerly more prevalent than it is now. It was not unusual to see many hundreds of cases of this ocular condition in the early spring of the year in the ophthalmic clinic of the New Haven Dispensary. The lesion was considered as tuberculous but the patient was treated with a well-balanced diet. In New Haven we observed that when the milk supply was improved there were few cases of phlyctenular keratoconjunctivitis to show the student body. One must conclude that phlyctenular keratoconjunctivitis is not a tuberculous condition but is due to

some form of dietary deficiency, for the condition was cleared up almost permanently by the use of a well balanced diet with good milk as an important component.

Many other ocular lesions have benefited by this form of vitamin therapy. There are numerous instances where patients afflicted with syphilitic interstitial keratitis regained healthy tissue after a short period of intensive ocular treatment together with a well balanced diet, plus cod-liver oil and vitamin B complex. Superficial punctate keratitis, having as its etiology some form of a low-grade infection of the fifth nerve, has been cured by the parenteral injection of large doses of vitamin B₁ (thiamin chloride), and vitamin B complex orally.

RETINITIS PIGMENTOSA

Although night blindness is the outstanding symptom in retinitis pigmentosa,* no definite improvement has been noted in advanced stages where a high vitamin diet is employed. The writer is satisfied that the visual acuity and field of vision in late stages of retinitis pigmentosa are not improved by constant oral administration of potent cod-liver oil, its concentrate, or its provitamin carotene. Vitamin B complex in large quantities was added to the vitamin A therapy, and vitamin B₁ (thiamin chloride) was injected parenterally, but the results were the same. The patients believe they see better during the day and find their way about better at night, yet the ocular examination of the visual acuity and fields as a rule show no improvement. When the neuro-epithelium is destroyed it is difficult to regenerate it; however this type of therapy should be continued for it is the best we have to offer these unfortunates.

It is the writer's impression that retinitis pigmentosa, if treated early with

*Chronic progressive degeneration consisting of atrophy of retina with characteristic deposit of pigment.

a high vitamin diet, may be held in abeyance. It is not only necessary to see that patients take enough of the vitamins; it is more important to ascertain whether the vitamins are being absorbed properly into the system. Fat soluble vitamin A is usually found in foods of animal origin; whereas in cereals, vegetables, fruits, and such dairy products as whole milk, cream, butter, and eggs, the vitamin exists mainly in its precursive form. It has been established that the precursive form is not active until the liver has converted it into vitamin A. It is therefore extremely important to determine the functional integrity of the liver in every patient with vitamin deficiency.

It is remarkable how quickly some active chorioretinal disturbances alleged to have a focal infection as the underlying cause clear up when the patient is given a well balanced diet enhanced by vitamin A and vitamin B complex. The general condition of the patient and the ocular disease are treated simultaneously. Focal infections are usually removed but not until the patient's general health is improved.

It has been shown that chronic alcoholism destroys the protein-digesting activity of certain gastro-intestinal enzymes. It is suggested that alcoholic polyneuritis or deficiency disease may be caused, in part at least, by faulty digestion and assimilation of food resulting from the destruction of digestive enzymes by large quantities of alcohol taken over a considerable period of time.

TOXIC AMBLYOPIA DUE TO ALCOHOL

In 1933, the writer reported the cure of toxic amblyopia due to alcohol and tobacco in patients who were allowed to smoke and to drink a moderate amount of alcohol when they were treated with a high vitamin diet. Similar results have since been reported by Carroll,¹⁴ who placed his patients under supervision in a hospital and observed cures

in those in whom the optic nerve was not atrophied. There are many instances of the cure of toxic amblyopia, when the offending drugs were removed and the general nutrition was improved, but at no time was the condition improved so rapidly as with a high vitamin therapy. It is apparent that toxic amblyopia may be associated with a deficiency disease, for in the light of what has been said it appears that alcohol taken over a long period of time destroys digestive enzymes and thus prevents the proper digestion and assimilation of food.

VITAMIN C DEFICIENCY

From the experimental work and the clinical observations made with natural vitamin C it became apparent that vitamin C not only protected from scurvy but had many other important functions. Outstanding among the pathological conditions due to vitamin C deficiency is a weakening of blood capillaries. The defect in the capillaries in vitamin C subnutrition was shown by Wolbach and Howe¹⁵ to result from a failure of the endothelial cells to form the intercellular cement substance, and these authors suggest that this failure extends to the connective tissue in other parts of the body.

The writer has treated many cases of hemorrhagic retinitis of various types with vitamin C and a balanced diet. The treatment seemed to shorten the length of time ordinarily required for the repair of this type of lesion.

It was noted, however, that synthetic vitamin C does not have the same effect upon retinal and vitreous hemorrhages as lemon juice. Lemon juice seems to clear the extravasation of blood and edema much more rapidly. There must be something in lemon juice that is more effective than synthetic vitamin C in breaking down and aiding in the absorption of hemorrhages of the vitreous, choroid, and retina.

All forms of natural vitamin C should

be used in the treatment of ocular lesions due to disturbance of the vascular wall. It must also be borne in mind that vitamin C is frequently not absorbed readily and that the source of the vitamin is variable.

VITAMIN G DEFICIENCY

Recently it was demonstrated that if the albino rat is fed a diet deficient in vitamin G (riboflavin), after a period of time inflammatory changes develop in the ocular tissue that ultimately produce characteristic opacities in the lens. Although not all the investigators observed cataracts with this deficiency ration, the ocular pathology was found frequently enough by others so that it may be accepted that vitamin G (riboflavin) plays an important role in the maintenance of healthy ocular tissue in the rat. In addition it has been noted that the general health and growth of the animal is interfered with when a diet deficient in vitamin G is fed.

CATARACT FORMATION IN ANIMALS

In contrast to this experience with a deficient diet it has been observed that experimental animals on high lactose diets develop changes in the lens leading to mature cataracts. It was apparent from this experiment with high lactose and other sugars that it was the galactose fraction of lactose which caused the changes in the ocular tissue. Similar disturbances in the lens of animals were produced by feeding them a diet of 25 percent and 35 percent galactose. The rats on this ration of galactose supplemented with adequate amounts of vitamins showed normal growth and maintained good health during the entire experiment. It was concluded from these experiments that the cataract was probably due to some metabolic disturbance unrelated to a vitamin deficiency.

It is extremely difficult to visualize the clinical picture of the formation of cataract in experimental animals if one

is not acquainted with the appearance of the changes in the lens as they are observed by the laboratory investigator. However, with the realization that the life span of a rat is short and every day of its existence may be regarded as equivalent to ninety days of a man; that the method used for producing the cataract is extreme; and that the development of the cataract in animals on a 50 percent or 35 percent galactose diet is so rapid that one stage of cataract formation blends right into another without giving an opportunity for differentiating the changes which take place, one may see some possible similarity between the experimental cataract and a type observed in man.

It is surprising how many opacities are found in the lens of persons past 50 years of age if the pupil is dilated and the extreme periphery examined. The lens changes in these instances are frequently insignificant and in many cases remain stationary for many years or advance so slowly that they may never interfere with vision. On the other hand there are some cases in which the lens changes may go on to further opacification of the lens tissue if the health of the patient is not improved or the source of toxin removed.

It has been shown that as age advances and activities in general are curtailed there is correspondingly less need for food. There are also certain individuals who show some of the so-called degenerative diseases such as arteriosclerosis, rheumatism, and others. Elderly persons require minerals, vitamins, and proteins to maintain good health even though the demand for the energy foods, carbohydrates, and fats, is greatly reduced. There is little doubt that many elderly persons could be restored to an active, healthy, happy existence by giving attention to their diet.

It seems obvious that not only the general health of the body but even that of the eye can be affected by faulty diet.

Like many other parts of the body it can share in any strain placed on the organism by an insufficient supply of various dietary essentials. Knowledge of this fact should be of great importance not only to those engaged in the treatment of ocular disorders but to students of nutrition, to public health and social workers, and to others who in

the course of their work may be called upon to give health advice of a general nature. For proper diagnosis and treatment of ocular conditions, it is evident that a person specially trained in ophthalmology is required.

Presented before the annual conference of the National Society for the Prevention of Blindness, New York, N. Y., October 26, 1939.

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THE AMERICAN JOURNAL OF NURSING FOR APRIL

The ICN Comes to the States.....	Calista Banwarth, R.N.
The Paste Treatment of Bed Sores.....	Mary L. Weston, R.N.
Treatment of Compound Injuries.....	Sumner L. Koch, M.D.
Hip Injuries and Nursing Care.....	Eleanor B. Pitman, R.N.
Nursing Isolation Procedures and How to Establish Them.....	Emma MacChesney, R.N.
"Miss Merling—I Need Work"	
Preparation for Delivery Service.....	Johanna Eggers, R.N.
Child Welfare in the Holy Land.....	Julietta K. Arthur
Health Service in a Nursing School.....	Elsie Davies, R.N., and Harriet Frost, R.N.
Proposed Revision of Bylaws of the A.N.A. and Proposed Revision of Bylaws of the Private Duty Section of the A.N.A.	

News from the S.O.P.H.N.'s

LIVELY and interesting discussions on current problems characterized the annual meeting of the Council of Branches of the National Organization for Public Health Nursing, on Sunday, January 28, just preceding the board meetings of the three national nursing organizations. With one exception all of the 19 state branches were represented.

STUDENT EDUCATION IN HEALTH

Nearly all the branches had asked advice from the Council on what assistance public health nurses and agencies may offer schools of nursing in order to help give students a concept of the preventive and health aspects of nursing. Most of the morning was therefore given over to this important subject. Participating in the discussion were Claribel Wheeler, executive secretary of the National League of Nursing Education, and Ruth Sleeper, chairman of the N.L.N.E. Committee on Curriculum.

The Council recommended that education committees of S.O.P.H.N.'s and curriculum committees of state leagues of nursing education form joint committees to study the problem of student education in public health. It was agreed that there should be representation from state boards of nurse examiners on these study committees, and that one of the committee activities might well be a study of standards for student field experience. Another suggested activity was assistance to nursing schools in securing vocational information about public health nursing for their libraries.

Chiefly, however, it is expected that these joint committees composed of instructors in nursing schools and public health nurses will study together the *Curriculum Guide for Schools of Nursing*, course by course, selecting the con-

tent related to health conservation, disease prevention, and the care of the sick in their homes. In this way it is expected that plans can be built up and suggested methods of teaching developed which can be offered to schools of nursing in each state. Miss Sleeper emphasized that whether or not student affiliation in public health nursing agencies or experience in outpatient departments is available, the student needs to have the best possible integration of these health aspects throughout the three years of her nursing education. It was agreed by the Council that a group of lectures on public health nursing unrelated to other parts of the curriculum is of very little help to the student.

In connection with the discussion of standards for agencies providing student affiliation, the suggested plan of the N.O.P.H.N. to adopt minimum requirements for its agency members was introduced. The Council voted to endorse this plan because it may tend to raise standards in some public health nursing agencies.

N.O.P.H.N. REPORTS AND REQUESTS

Reports about various special projects and section activities of the National Organization were presented and discussed during the afternoon session.

Dorothy Deming, the general director, asked Branches to note and report to the National any development in their states with regard to the following:

1. Bedside care by public health nurses, whether given by nurses in health departments or made possible through the formation of new voluntary agencies.
2. New standards set up for qualifications of public health nurses appointed to positions in departments of health which receive money from the United States Children's Bureau. As a result of the amendment to the Social Security Act which requires the establishment and maintenance of personnel standards on a

merit basis, changes in standards are to be expected.

3. Group hospital or medical care plans in states, especially if they are looking toward inclusion of medical and nursing service in the homes.

The new orthopedic project which is financed by an appropriation from the National Foundation for Infantile Paralysis was described by Jessie L. Stevenson, orthopedic consultant of the N.O.P.H.N. Plans for the project center around education of public health nurses in orthopedics from two points of view: (1) education of the generalized public health nurse through staff education, group conferences, and a manual on orthopedics for nurses which will be prepared by Miss Stevenson (2) preparation of the nurse specializing in orthopedic care, through the development of sound postgraduate courses.

The Council voted to recommend the formation of orthopedic committees in S.O.P.H.N.'s to assist with the orthopedic project of the N.O.P.H.N., and when occasion arises, to make suggestions to county chapters of the National Foundation for Infantile Paralysis in regard to services needed for the crippled in their areas.

Marie Swanson, chairman of the School Nursing Section, asked for help in securing nurse candidates for the scholarship offered by the Massachusetts Institute of Technology. She called attention to Biennial Convention plans of the School Nursing Section and the fact that the N.O.P.H.N. is represented on the newly formed National Conference for Cooperation in School Health Education.

Joanna Johnson, chairman of the Industrial Nursing Section, made a plea for including industrial nurses in plans and programs of S.O.P.H.N.'s.

The ever-important problem of securing the membership and participation in the N.O.P.H.N. and S.O.P.H.N.'s of people who are not nurses was the last topic considered by the Council. It was agreed that interest must be secured before membership can be expected. Hence, those who are not members should be encouraged to attend meetings. Moreover, interest cannot be maintained unless there is opportunity for participation in committee activities and other work.

Three active lay members took part in this discussion: Mrs. John Seaman, president of the Massachusetts S.O.P.H.N.; Mrs. Roger Young, chairman of the New Jersey S.O.P.H.N. Lay Section; and Mrs. Frederick Dellenbaugh, chairman of the Board and Committee Members' Section of the N.O.P.H.N.

The Council chose Edna Hamilton of the Michigan branch for chairman and Mathilda Scheuer of the Pennsylvania branch for vice-chairman of the Council during 1940. Ruth Houlton of the N.O.P.H.N. staff will continue as secretary.

The Council also welcomed the delegate of the newly formed S.O.P.H.N. of Montana, and voted to recommend to the Board of Directors of the N.O.P.H.N. that this new organization be accepted as a branch of the National.

It was decided to hold a dinner meeting for representatives of state branches at the Biennial Convention, when there will be further opportunity for a discussion of branch activities and problems.

Following the meeting, delegates were entertained at tea by the N.O.P.H.N.

EDNA L. HAMILTON, *Chairman*
Council of Branches

NOTES *from the* NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

HONOR ROLL

Have you received your 1940 Certificate of Honor yet? If you have not and the name of your service does not appear on the Honor Roll published in this magazine, be sure to let us know. For there is a place on the 1940 Roll of Honor for each agency—whether it has one nurse or several.

Just be sure all the nurses on your staff are enrolled in the N.O.P.H.N. for this year—then don't forget to drop us a card telling us that you are 100 percent enrolled. We'll make sure that your association is on the next list published and that you receive your Honor Roll Certificate as a reward for your loyalty and cooperation.

Almost 300 agencies have received their 1940 Certificates and we are indeed grateful to all the nurses who have made this possible by their memberships.

ALABAMA

Greene County Health Department,
Eutaw
Metropolitan Life Insurance Nursing
Service, Gadsden
Franklin County Health Department,
Russellville
Randolph County Health Department,
Wedowee

CALIFORNIA

Metropolitan Life Insurance Nursing
Service, Richmond
*Metropolitan Life Insurance Nursing
Service, San Bernardino

COLORADO

Akron Public Health Department, Akron
*Colorado Tuberculosis Association, Den-
ver
Health Service Department of the Denver
Public Schools, Denver
*Metropolitan Life Insurance Nursing
Service, Denver
*Visiting Nurse Association, Denver
Routt County Public Health Service,
Hayden

CONNECTICUT

*Visiting Nurse Association of Bridgeport,
Bridgeport
*Public Health Nursing Association,
Darien

FLORIDA

Metropolitan Life Insurance Nursing
Service, Pensacola

ILLINOIS

Bellwood School Nursing Service, Bell-
wood
Bellwood Welfare and Health Organiza-
tion, Bellwood
Champaign Urbana Public Health Dis-
trict, Champaign
Public Health District, Quincy
Adams County Anti-Tuberculosis League,
Quincy
Gallatin County Nursing Service, Ridg-
way

INDIANA

Knox County Health Department, Bick-
nell
*Lake County Health Department, Crown
Point
*Elkhart Child Welfare Station, Elkhart
*Delaware County Tuberculosis Associa-
tion, Muncie

IOWA

*Visiting Nurse Association, Council Bluffs
Public Health Nursing Association, Des
Moines
Jackson County Nursing Service, Maquo-
keta
*Public Health Nursing Association, Mus-
catine
Metropolitan Life Insurance Nursing
Service, Ottumwa
*Waterloo Visiting Nursing Association,
Waterloo
Alamakee County Public Health Nursing
Service, Waukon

KANSAS

Great Bend Public School Nursing Serv-
ice, Great Bend
Public Health Nursing Association,
Salina

KENTUCKY

Metropolitan Life Insurance Nursing
Service, Frankfort
Metropolitan Life Insurance Nursing
Service, Madisonville

LOUISIANA

*Metropolitan Life Insurance Nursing
Service, New Orleans

MARYLAND

Caroline County Health Department,
Denton
The Federated Charities, Frederick

*Agencies which have been on the Honor Roll
for five years or more.

MASSACHUSETTS

- *Visiting Nurse Association, Lowell
- Pembroke Public Health Nursing Association, Pembroke
- *Visiting Nurse Association, Springfield

MICHIGAN

- Genesee County Health Department, Flint

MISSOURI

- *Visiting Nurse Association of Kansas City, Kansas City
- Barton County Nursing Service, Lamar
- Clay County Nursing Service, Liberty
- Randolph County Public Health Nursing Service, Moberly
- Lewis County Public Health Nursing Service, Monticello
- Sireston Public School, Oran
- Washington County Nursing Service, Potosi
- *Visiting Nurse Association, St. Louis
- Pettis County Public Health Nursing Service, Sedalia
- Platte County Nursing Service, Platte City
- Grundy County Nurses Office, Trenton

MONTANA

- Department of Public Health and Hygiene, Great Falls
- Phillips County Health Department, Malta

NEBRASKA

- Demonstration District Health Unit No. 1, Gering
- Omaha Public Schools, Omaha
- Visiting Nurse Association, Omaha

NEW HAMPSHIRE

- *Good Cheer Society, Nashua

NEW JERSEY

- *Metropolitan Life Insurance Nursing Service, Asbury Park
- Greenwich Township Board of Education, Gibbstown
- *Montclair Bureau of Public Health Nursing, Montclair
- Northern Bergen Nursing Service, Ramsey
- Salem City Board of Education, Salem
- Audubon Board of Education, West Collingswood

NEW YORK

- Metropolitan Life Insurance Nursing Service, Amsterdam
- *Cayuga Health Association, Auburn
- Westchester Center—Henry Street Visiting Nurse Service, Bronx
- Bay Ridge Office of Brooklyn Visiting Nurse Association, Brooklyn
- Coney Island Sub-Station of Visiting Nurse Association of Brooklyn, Brooklyn
- East New York Office of Brooklyn Visiting Nurse Association, Brooklyn
- Navy Yard Office of Brooklyn Visiting Nurse Association, Brooklyn

- Metropolitan Life Insurance Nursing Service, Herkimer and Little Falls
- Queens Metropolitan Western Nursing Service, Jackson Heights
- Metropolitan Life Insurance Nursing Service, Middletown
- Highbridge Center—Henry Street Visiting Nurse Service, New York
- Metropolitan Life Insurance Nursing Service, Peekskill
- *Village Welfare Society, Port Washington
- *Visiting Nurse Association of Staten Island, St. George

NORTH CAROLINA

- *Metropolitan Life Insurance Nursing Service, Gastonia
- Robeson County Department of Health, Lumberton
- Rutherford-Polk District Health Department, Rutherfordton
- Martin County Health Department, Williamston

OHIO

- Visiting Nurse Association of Cleveland—Branch No. 2, Cleveland
- Visiting Nurse Association of Cleveland—Branch No. 6, Cleveland
- *Lima Visiting Nurse Association, Lima
- *Toledo District Nurse Association, Toledo

OKLAHOMA

- *Public Health Association, Tulsa

OREGON

- *Oregon Tuberculosis Association, Portland

PENNSYLVANIA

- Babies Hospital of Philadelphia, Philadelphia
- *Visiting Nurse Association of Scranton and Lackawanna County, Scranton

RHODE ISLAND

- *Cranston District Nursing Association, Cranston
- Newport Hospital School for Nurses, Newport
- *Woonsocket Public Health Nursing Association, Woonsocket

TENNESSEE

- *Metropolitan Life Insurance Nursing Service, Memphis

TEXAS

- Houston Visiting Nurse Association, Houston

VIRGINIA

- *Fairfax County Health Department, Fairfax
- Norfolk-Princess Anne Counties Health Department, Portsmouth
- Metropolitan Life Insurance Nursing Service, Roanoke

WASHINGTON

- *Metropolitan Life Insurance Nursing Service, Spokane

*Agencies which have been on the Honor Roll for five years or more.

*Metropolitan Life Insurance Nursing Service, Tacoma

WEST VIRGINIA

*Charleston Public Health Nursing Association, Charleston

WISCONSIN

County of Sauk Nursing Service, Barabou
Brown County Public Health Committee,
Green Bay

Door County Health Department Nursing Service, Sturgeon Bay

Metropolitan Life Insurance Nursing Service, Wisconsin Rapids

ALASKA

Angoon Office of Indian Affairs, Angoon

VIRGIN ISLAND

St. Croix Department of Health, Christianstad, St. Croix

VISIT PHILADELPHIA SCHOOLS

An invitation to visit the school nursing services in and around Philadelphia, Pa., has been extended to school nurses on the following dates: Monday, May 13, all day; Wednesday, May 15, afternoon only; Thursday, May 16, afternoon only. Those interested should apply directly as indicated: for suburban schools, Mrs. Lois Owen, school nursing adviser, Pennsylvania Department of Public Instruction, Harrisburg; for Philadelphia public schools, Edith Bishop, supervisor of nurses, The Board of Public Education, Parkway at 21 Street, Philadelphia; for Philadelphia parochial schools, Gertrude Leddy, supervisor of parochial school nurses, City Hall Annex, Room 602, Philadelphia.

CONVENTION MANAGER

Ida F. Butler has been engaged to serve as manager for the 1940 Biennial Convention of the three national nursing organizations, to be held in Philadelphia, May 12-18.

Miss Butler's broad experience in

nursing and her service as chairman of the Local Committee on General Arrangements for the Biennial Convention held in Washington, D.C., in 1934 gives her an excellent background for the responsibilities which she will be called upon to assume in this capacity.

Miss Butler came to New York March 1, and after spending a period of time at Headquarters will go to Philadelphia in order to be of all possible assistance to the Local Arrangements Committee.

NIGHTINGALE PORTRAIT

Nurses who go through Pittsburgh on their way to the Biennial Convention are cordially invited to stop in Pittsburgh and see the famous picture of Florence Nightingale that hangs in the nurses' home of the Western Pennsylvania Hospital. The picture was painted in 1872 by the Scottish painter, George Paul Chalmers. It is possible to secure photographic copies of the original portrait and orders will be taken at the booth of the Pennsylvania State Nurses' Association in the exhibit area at the Biennial Convention.

BLOCKLEY ALUMNAE TEA

Blockley graduates are invited to a tea to be given by the Philadelphia General alumnae at the nurses' home of the Philadelphia General Hospital, May 16.

"YOUR N.O.P.H.N."

The series of articles on the National Organization for Public Health Nursing, published under the title "Your N.O.P.H.N.," and our usual column "With the Staff" will be resumed in the May issue. Both had to be omitted this month because of pressure of Biennial Convention material.

BYLAWS

The following are proposed revisions to the Bylaws of the National Organization for Public Health Nursing, a copy of which will be mailed to each member along with her ballot at least one month before the convention.

PRESENT BYLAW

ARTICLE V

COMMITTEES

SECTION 1.—*Standing Committees.*

PROPOSED ADDITION

ARTICLE V

COMMITTEES

SECTION 1.—*Standing Committees.*

4. *Eligibility Committee*

The Eligibility Committee shall be composed of seven members chosen by the Board of Directors, one of whom shall be designated chairman. It shall be the duty of this committee to establish requirements for membership where requirements are not explicitly set forth in these bylaws and pass upon applications for all forms of membership.*

PRESENT BYLAW

ARTICLE VII

BRANCHES

3. Renders an annual report of its program, activities and officers to the N.O.P.H.N.

PROPOSED REVISION

ARTICLE VII

BRANCHES

3. Renders an annual report of its program and activities and sends a list of its officers to the N.O.P.H.N.

*This proposed bylaw gives power to the Eligibility Committee to set agency membership qualifications as accepted by the Board of Directors. The requirements were published in the November 1939 number of PUBLIC HEALTH NURSING and accepted by the Board in January 1940.

FOR ELECTION AT BIENNIAL

The Nominating Committee presents the following list of candidates for officers and directors of the National Organization for Public Health Nursing for the biennial period 1940-1942.

This slate is presented in accordance with the revision of the Bylaws adopted by the membership at Kansas City, Missouri, in 1938, on recommendation of the Committee to Study the Functions of the National Organization for Public Health Nursing.*

These revisions were called to the attention of the N.O.P.H.N. membership in the October 1939 issues of both PUBLIC HEALTH NURSING and *Listening In*.

The suggestions sent in are embodied in the ballot which is presented here. Space is still left for you to vote (by writing in the name) for another candidate than the one presented, if you so desire, when you receive your official ballot.

SOPHIE C. NELSON, *Chairman*
HELEN BOND
MARY J. DUNN
EMILIE SARGENT
WILLIAM P. SHEPARD, M.D.

* PUBLIC HEALTH NURSING, April 1938, p. 240.

N.O.P.H.N. BALLOT

PRESIDENT

☐ Grace Ross, R.N., Detroit, Mich.* ☐

FIRST VICE-PRESIDENT

☐ Marion G. Howell, R.N., Cleveland, Ohio* ☐

SECOND VICE-PRESIDENT

☐ Mrs. Charles S. Brown, New York, N.Y. ☐

TREASURER

☐ W. Lawrence McLane, New York, N.Y.* ☐

SECRETARY

☐ Dorothy Deming, R.N., New York, N.Y.* ☐

DIRECTORS—NURSE MEMBERS

Vote for six

☐ Mary Beard, R.N., Washington, D.C. ☐
☐ Lula P. Dilworth, R.N., Trenton, N.J.* ☐
☐ Laura A. Draper, R.N., Minneapolis, Minn. ☐
☐ Rena Haig, R.N., San Francisco, Calif. ☐
☐ Ruth W. Hubbard, R.N., Philadelphia, Pa.* ☐
☐ Marion W. Sheahan, R.N., Albany, N.Y.* ☐

DIRECTORS—NON-NURSE MEMBERS

Vote for five

☐ Erval R. Coffey, M.D., Washington, D.C. ☐
☐ Martha M. Eliot, M.D., Washington, D.C. ☐
☐ Felix J. Underwood, M.D., Jackson, Miss. ☐
☐ W. Frank Walker, D.P.H., New York, N.Y.* ☐
☐ Abel Wolman, Dr.Eng., Baltimore, Md.* ☐

DIRECTORS—NON-NURSE MEMBERS

(Representing board and committee members of local public health nursing organizations)

Vote for three

☐ Mrs. F. S. Dellenbaugh, Jr., Boston, Mass. ☐
☐ Mrs. John S. Haskell, St. Louis, Mo. ☐
☐ Mrs. Adrian Van Sinderen, Brooklyn, N.Y. ☐

NOMINATING COMMITTEE 1940-1942

Vote for five

☐ Raymond Clapp, Indianapolis, Ind. ☐ Ruth Mettinger, R.N., Jacksonville, Fla.
☐ Mrs. Gammell Cross, Providence, R.I. ☐ Jane D. Nicholson, R.N., Washington, D.C.
☐ Phyllis M. Dacey, R.N., Kansas City, Mo. ☐ Olivia T. Peterson, R.N., Minneapolis, Minn.
☐ Katharine Faville, R.N., New York, N.Y. ☐ Marguerite Wales, R.N., Battle Creek, Mich.
☐ Anna Heisler, R.N., San Francisco, Calif. ☐ Estella Ford Warner, M.D., Albuquerque, N.Mex.

* For reelection.

Biographical data in regard to the candidates will be sent to the members with the ballot.

GROUP CONFERENCES PRIOR TO THE BIENNIAL

The group conferences which are planned by the N.O.P.H.N. for the Saturday and Sunday (May 11 and 12) just preceding the Biennial Convention in Philadelphia are described below with additional details. The tentative announcement appeared in the January issue, page 57. Registrations stating name, address, position, N.O.P.H.N. membership if a member, name of institute, and registration fee should reach the N.O.P.H.N. office, 50 West 50 Street, New York, N. Y., before April 15. Registrations will be accepted in order of application and notification will be sent of acceptance.

Business Administration. Leader, Lucretia H. Royer, N.O.P.H.N. business manager. Assistance from an expert in the field. Open to from 30 to 60 people, representatives from agency members, preferably business managers or directors. Only one representative from each agency member may attend.

Sessions: Sunday, May 12, afternoon.

Registration fee: \$1.50.

Eye Health. Leader, Eleanor W. Mumford, associate for nursing activities, National Society for the Prevention of Blindness. Open to 35 supervisors or instructors in public health nursing, course or educational directors, and instructors in schools of nursing.

Sessions: Saturday, May 11, all day.

Sunday, May 12, half day.

Registration fee: \$2 to N.O.P.H.N. members; \$4 to nonmembers.

Industrial Hygiene. Leader, J. J. Bloomfield, sanitary engineer, Federal Security Agency, United States Public Health Service, Washington, D. C. Open to from 30 to 60 nurses.

Sessions: Saturday, May 11, all day.

Sunday, May 12, half day.

No registration fee. (This is a correction of announcement in January issue.)

Maternity. Anita Jones, assistant director, Maternity Center Association, New York, N. Y. Open to from 30 to 60 nurses.

Sessions: Saturday, May 11, all day.

Sunday, May 12, half day.

Registration fee: \$2 to N.O.P.H.N. members; \$4 to nonmembers.

Orthopedic Nursing. Subject: Planning a staff education program in orthopedic nursing. Leader, Jessie L. Stevenson, N.O.P.H.N. assistant director. Open to 30 supervisors or nurses responsible for orthopedic program.

Sessions: Saturday, May 11, all day.

Sunday, May 12, half day.

No registration fee.

Records. Marion Randall, assistant director in charge of Records and Statistics, Henry Street Visiting Nurse Service, New York, N. Y. Open to from 30 to 60 people.

Sessions: Saturday, May 11, all day.

Sunday, May 12, half day.

Registration fee: \$2 to N.O.P.H.N. members; \$4 to nonmembers.

School Nursing.

Conference for nurses in the elementary schools. Leader, Marie Swanson, state supervisor of school nursing, New York State Education Department.

Conference for nurses in the secondary schools. Leader, Lula P. Dilworth, associate in health and safety education, New Jersey State Department of Public Instruction. Both conferences are open to from 30 to 60 nurses.

Sessions: Saturday, May 11, all day.

Sunday, May 12, half day.

Registration fee: \$2 to N.O.P.H.N. members; \$4 to nonmembers.

Social Hygiene. Leader, Mrs. Evangeline Hall Morris, instructor, School of Nursing, Simmons College, Boston, Mass. Open to from 30 to 60 nurses.

Sessions: Saturday, May 11, all day.

Sunday, May 12, half day.

Registration fee: \$2 to N.O.P.H.N. members; \$4 to nonmembers.

Tuberculosis. Leader, Fannie Eshleman, supervisor of nurses, The Henry Phipps Institute, Philadelphia, Pa. Open to supervisors, educational directors, and directors of generalized and specialized public health nursing services.

Sessions: Saturday, May 11, all day.

Sunday, May 12, half day.

Registration fee: \$2 to N.O.P.H.N. members; \$4 to nonmembers.

N.O.P.H.N. BIENNIAL PROGRAM**PHILADELPHIA, PENNSYLVANIA, MAY 12-18****Monday, May 13**

10:45-12:00. N.O.P.H.N. Board of Directors (closed meeting)

1:00-2:30. Luncheon: N.O.P.H.N. (Sponsored by Industrial Nursing Section)

Speaker: Henry F. Vaughan, Dr.P.H., Commissioner, City Department of Health, Detroit, Mich.

2:30-4:00. Round Tables:

Rural Home Delivery Service

Leader: Mable O. Olson, supervisor, Polk County Obstetrical Service, Des Moines, Ia.

The Merit System—Its Philosophy and Application

Leader:

Marion W. Sheahan, director, Division of Public Health Nursing, State Department of Health, Albany, N. Y.

Tuberculosis in Industry

Leader: (to be announced)

4:30-6:00. Special Round Table

4:30-6:00. Informal Discussion and Tea—Board and Committee Members' Section

Tuesday, May 149:00-10:30. N.O.P.H.N. General Session—**Working Together in the Community**

Presiding: Grace Ross, director, Division of Nursing, City Department of Health, Detroit, Mich.

Speakers:

Kenneth L. M. Pray, professor of social planning and administration, Pennsylvania School of Social Work, Philadelphia, Pa.

Ira V. Hiscock, professor of public health, The School of Medicine, Yale University, New Haven, Conn.

10:45-12:00. N.O.P.H.N. Business Session. (Open only to 1940 members by membership card)

1:00-2:30. Luncheon: N.O.P.H.N. Membership Rally

2:30-4:00. Round Table

Earnings in Public Health Nursing Agencies

Leader: Helen Reynolds, director, Visiting Nurse Association, San Francisco, Calif.

2:30-4:00. Panel

How Can School and Community Join Forces to Serve the School Child?

Leader: Geraldine Hiller, school nurse, New Rochelle, N. Y.

4:30-6:00. Special Round Tables

The Operation of a Mothers' Milk Bureau

Leader: Mrs. Helen F. Leighty, director, The Children's Welfare Federation of New York City, Inc., New York, N. Y.

Costs in Public Health Nursing Agencies

Leader: Hazel Dudley, director and Red Cross nursing field representative, State Department of Health, Hartford, Conn.

Camp Nursing

Leader: Mrs. Kathryn O. Brownell, director, Y.W.C.A. School of Practical Nursing, Brooklyn, N. Y.

4:30-6:00. Tea. Board and Committee Members' Section—Hostesses, Board of Directors, Philadelphia Visiting Nurse Society

7:00. Dinner. N.O.P.H.N. Council of Branches

Wednesday, May 1510:45-12:00. N.O.P.H.N. General Session—**Newer Knowledge in Nutrition**

Presiding: Melva Bakkie, nutrition consultant, American Red Cross, Washington, D.C.

Speakers:

Elda Robb, assistant professor, Home Economics, Temple University, Philadelphia, Pa.

Mrs. Anna dePlanter Bowes, chief of the Division of Nutrition, Pennsylvania State Department of Health, and director, Nutrition Education, Philadelphia Child Health Society, Philadelphia, Pa.

1:00-2:30. Luncheon: N.O.P.H.N. School Nursing Section (Business Meeting)

Seeing Yourself as Others See You—W. H. Blake, Ph.D., Teachers College, Columbia University, New York, N.Y.

2:30-4:00. Sightseeing

7:00. Dinner: N.O.P.H.N. (sponsored by Board and Committee Members' Section)

Presiding: Mrs. David Remer, Chestnut Hill, Pa.

Housing and Health—C.-E. A. Winslow, Dr.P.H., The School of Medicine, Yale University, New Haven, Conn.

Thursday, May 16

2:30-4:00. Round Tables

Student Affiliation in Public Health Nursing Agencies*

Leaders:

Ruth Sleeper, assistant principal, Training School for Nurses, Massachusetts General Hospital, Boston, Mass.

Ruth W. Hubbard, general director, Visiting Nurse Society of Philadelphia, Pa.

Radio Publicity

Leader: (to be announced)

4:30-6:00. Special Round Tables

Supervision in School Nursing

Leader: Louella L. Haage, supervisor of school nurses, Board of Education, Jersey City, N. J.

College Nursing

Leader: Raidie Poole, college nurse and instructor of physiology and hygiene, State Teachers College, Superior, Wis.

4:30-6:00. Informal Discussion and Tea—Board and Committee Members' Section

Friday, May 17

9:00-10:30. N.O.P.H.N. General Session—**Leadership Through Supervision**

Presiding: Mathilda Scheuer, educational director, Visiting Nurse Society of Philadelphia, Pa.

Speakers:

Virginia P. Robinson, assistant director, professor of social case work, Pennsylvania School of Social Work, Philadelphia, Pa.

Louise Knapp, professor of nursing and director of nursing education, Wayne University, Detroit, Mich.

10:45-12:00. N.O.P.H.N. Business Session (open only to 1940 members by membership card)

For the joint program of the three national nursing organizations see the March issue, p. 213.

The programs of the American Nurses' Association and the National League of Nursing Education are published in the April issue of *The American Journal of Nursing*.

*In conjunction with the National League of Nursing Education.

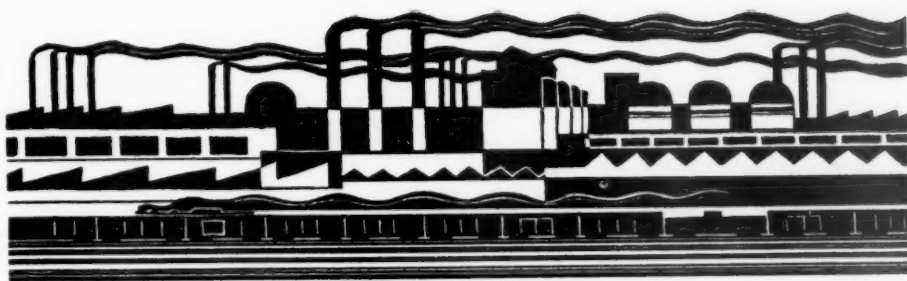
INVITATIONS TO 1942 BIENNIAL CONVENTION

STATES that wish to invite the three national nursing organizations to hold the 1942 Biennial Convention in one of their cities are asked to meet the following conditions:

Before a state issues an invitation to the three national nursing organizations to hold a Biennial Convention in a specified city, *written* assurance must be presented to the three national nursing organizations, signed by the official representative of some responsible body or bodies, that facilities such as convention halls, exhibit hall, and additional meeting places are available free of charge. Also, that the nursing groups in the state (or states) are willing to cooperate in the undertaking.

Invitations should be endorsed by the three state organizations—the state nurses' association, the state league of nursing education, and the state organization for public health nursing. The facilities offered by the city issuing the invitation should be carefully described, giving full details.

For further information write to Mrs. Alma H. Scott, chairman of the National Biennial Headquarters Committee, 50 West 50 Street, New York, N. Y.



INDUSTRIAL HYGIENE SYMPOSIUM

AN industrial hygiene symposium for industrial nurses was held in Chicago, Illinois, October 26-28, 1939. The plan originated with the Chicago Industrial Nurses Association at whose request the Illinois State Department of Health planned the program, secured the speakers, and made all arrangements for the meetings.

Other sponsors were the American Medical Association, the American Industrial Hygiene Association, the Illinois Manufacturers Association, the Greater Chicago Safety Council, and the University of Illinois Medical School.

The interest in these meetings was shown by the registration of 187 nurses, including representatives from ten states—Illinois, Indiana, Iowa, Michigan, Minnesota, Missouri, New York, Ohio, Tennessee, and Wisconsin. Chicago industries were represented by 104 nurses; Illinois, outside Chicago, by 54; and other states, 56.

A conducted trip through the first-aid departments of three large industries—the Crane Company, the International Harvester Company, and the Westinghouse Electric and Manufacturing Company—was one of the features of the symposium. The nurses indicated their choice of the company they wished to visit and were met at each plant at 10 a.m. by the company representatives. All the nurses were invited to lunch at the plants they were visiting.

A large dinner meeting held on Octo-

ber 27 at the General Federation of Women's Clubs was attended by many interested persons outside the nursing profession. The three speakers on the program were: Dr. Joseph H. Chivers, medical director, Crane Company; Harry Guilbert, director, Bureau of Safety and Compensation, The Pullman Company; and B. K. Richardson, chief, Division of Public Health Instruction, Illinois State Department of Public Health. All three were enthusiastically received.

Suggestions of special value which were made at the various sessions included ways of keeping and making use of records; a method of drawing helpful conclusions from accurately kept statistics; and an outline of community facilities and agencies which the nurse can call upon for the benefit of the worker. Other subjects discussed on the program were compensation laws, communicable diseases, the state public health program, interviewing the worker, possibilities for improvement in the nutrition program, and the modern treatment of pneumonia.

The consensus was that the meetings had been extremely educational and stimulating and that a yearly event of this kind would be welcome. The Chicago Industrial Nurses Association is greatly indebted to the following members of the Illinois State Department of Health for their assistance in arranging for the meetings: A. C. Baxter, director;

M. H. Kronenberg, M.D., chief, Division of Industrial Hygiene; Corrine Robinson, state supervising nurse.

A similar symposium is planned by

the industrial nurses in Wisconsin for 1940.

CHRISTIAN F. SEABROOK, R.N. *President, Chicago Industrial Nurses Association*

MEETING IN MASSACHUSETTS

The Industrial Nursing Section of the Massachusetts Organization for Public Health Nursing will hold its spring meeting at the Hotel Bancroft, Worcester, April 13, at 4:00 p.m. The program is as follows:

4:00 p.m. Business meeting

5:00 p.m. "Let Us Be Aware," by Hannah Simmons, M.D.

6:00 p.m. Dinner meeting

Presiding: Louise Fiske, Ginn and Company, Cambridge, Mass., assisted by Yvonne Beaulieu, Perkins Machine and Gear Company, Springfield, Mass.

Address of welcome, William E. Bennett, Mayor of Worcester

"Allergy," William B. Clapp, M.D., North Grafton

"Human Relations," Ralph Bevan, manager, Connecticut General Life Insurance Company, Worcester

Music, Marjorie Taylor Trio

Short talks will also be given by Dr. John Kiniry, plant physician, Wickwire Spencer Steel Company, Worcester, Mass.; Margaret L. Boyle, president, Massachusetts State Nurses' Association; and Mrs. John H. Seaman, president, Massachusetts State Organization for Public Health Nursing.

CATHERINE R. DEMPSEY, R.N.

Chairman Industrial Nursing Section

INDUSTRIAL NURSES AT THE BIENNIAL

Industrial nursing is given a more important place in the program of this Biennial Nursing Convention than ever before—a recognition of its growing importance in the field of public health. The Industrial Nursing Section of the National Organization for Public Health Nursing is planning a series of meetings in which industrial nurses will have an opportunity to discuss their problems together and to hear authoritative speakers on industrial subjects. Prior to the convention a group conference or institute on industrial hygiene will be held on Saturday and Sunday, May 11 and 12. (See page 274, this issue, and page 218, March issue.) Registrations

should reach the N.O.P.H.N. office, 50 West 50 Street, New York, N. Y., by April 15. There is no registration fee.

"Opportunities for Nurses in Industry" will be the subject of a luncheon on Monday, May 15, which will be open to all nurses at the convention. Following the luncheon, "Tuberculosis in Industry" will be the subject of the afternoon session. Informal round tables will be arranged for the late afternoons between 4:30 and 5:30, Monday through Thursday, for the discussion of problems and topics suggested by industrial nurses attending the convention.

Details of the complete N.O.P.H.N. program will be found on page 275.



EDITED BY ANNA C. GRING

WAYS TO COMMUNITY HEALTH EDUCATION

By Ira V. Hiscock, Dr.P.H. 306 pp. The Commonwealth Fund, New York, 1939. \$3.

Leaders in health education expect a great deal from the public health nurse. A reader of this book must feel sympathy and a kind of awe that any one person—any one woman, indeed—must and can do so much.

While the nurse bathes the new baby or makes grandmother more comfortable, her eye travels about the kitchen noting what is needed for safety in the home. She inquires casually about vaccination, tactfully advises immunization, and explains the need for early examination to detect syphilis, tuberculosis, or cancer, all the while trying to "establish relationships with her patients that will develop their confidence in her advice."

Fortunately the nurse does not carry the whole load of health education in her community. This book describes the background of national, state, and local programs of education against which her own individual home teaching is carried on. The title of Chapter X, *Some Aids on the Job*, well describes the usefulness of this practical handbook to the public health nurse. The aids include excellent reading lists; sources for health education material; accounts of specialized health educational campaigns sponsored by national agencies; and many suggestions on how to use organizations in the community and the

various channels of communication, such as meetings, newspaper, printed matter, radio, exhibits, and motion pictures, in carrying on health education.

MARY SWAIN ROUTZAHN
New York, New York

GONORRHEA IN THE MALE AND FEMALE

By P. S. Pelouze, M.D. 489 pp. W. B. Saunders Company, Philadelphia, third edition revised, 1939. \$6.

The year 1928 marked the beginning of a new era in the management of gonorrhea; an era in which gentle handling, mild medication, and a generous portion of common sense were to displace roughness, irritating antiseptics, overpromoted biologicals, and a vast accumulation of traditional trash. It was Pelouze who, almost single-handed, after many years of experience and discriminating observation, turned the trick, when he presented to an astonished and grateful medical profession his book, *Gonococcal Urethritis in the Male*. This first edition was translated into foreign languages, became the manual of procedure over the greater part of the world, and in 1931, was followed by a second edition, *Gonorrhea in the Male and Female*.

Since the publication of this second edition, the sulfonamides have appeared upon the scene. Pelouze had seen many therapeutic preparations come and go, and his conservative reception of these

new drugs has been justified by the subsequent, more calm evaluation of them. Although they have replaced hopelessness with hopefulness for the control of gonorrhea, they are no more than an excellent addition to the therapeutic armamentarium. They are most effective, moreover, when used in conjunction with those procedures advocated by Pelouze more than ten years ago.

The third edition of the book retains the punch and common sense of the earlier editions, although most of the material is new. The sixteen entirely new chapters are a monument to the progress which has been made during the last five or six years in the diagnosis and treatment of the disease. Hyperthermia, hormone therapy, and the sulfonamides are carefully evaluated, and the advances made in the culture of the gonococcus are related to the need for better diagnostic procedures, and for entirely new standards for the determination of cure. To all this has been added an excellent section on the current control program.

The book still holds its place as the manual of the management of gonorrhea. The physician who would treat the disease intelligently, and the health officer, nurse, or social worker who would help to control it, must first understand it. The most direct route to such an understanding is through the pages of this book.

N. A. NELSON, M.D.
Boston, Massachusetts

THE PATIENT AS A PERSON

By G. Canby Robinson. 414 pp. The Commonwealth Fund, New York, 1939. \$3.

The contribution of this book lies in form and language rather than in essential content. If the medical student has not yet accepted the social aspects of illness as a component of the medical picture, nurses have struggled with this problem for years. Guidance toward

better expression and classification of observations in this field was needed, and is furnished in this volume.

Chapter Nine, Treatment of the Patient as a Whole, and Chapter One, Elements of Illness and Their Relation to Medical Service, are of interest. The case material lacks penetration and the emphasis remains on the medical side. Patients as persons are important; how much more revealing would persons as patients be.

The bibliography is outstanding.

GERTRUDE ZURRER, R.N.
West Haven, Connecticut

PARENTHOOD IN A DEMOCRACY

By LeRoy E. Bowman and Margaret Lighty. 236 pp. Published for the Robert E. Simon Memorial Foundation by The Parents' Institute, New York, 1939. \$1.50.

This book illustrates the truism—too often ignored by workers interested in child welfare—that of all groups the people best endowed to help children are their own parents.

Nevertheless, it emphasizes the fact that many parents in America realize they cannot assume responsibility for the whole job of successfully rearing their children. Neither do they wish to attempt a feat too complicated for a single group. However, there is no lack of evidence of their willingness, and more important still, their capability for doing their part.

These parents appear to recognize the fact that the surest way of preserving a democracy for future generations is to inculcate democratic principles in the upbringing of children. They believe that both home and school atmosphere should contribute to the molding of the character of children, to an appreciative understanding of the democratic way of life, and to a desire to perpetuate democracy.

BERTHA M. JENKINS
New York, New York

NEWS NOTES

- Readers who are interested in the housing program will want to be informed on Bill S-591 to amend the U. S. Housing Act, passed by the Senate on June 8, 1939, and now awaiting action by the House of Representatives. The Bill extends the lending power of the United States Housing Authority by \$800,000,000 of which \$200,000,000 is to be used for rural housing. It also provides for cooperation between the United States Housing Authority and the Department of Agriculture in developing the rural housing program. Further information can be obtained from National Executive of Housing Authorities, Barr Bldg., Washington, D. C.

- The American Association for Adult Education will hold its fifteenth annual meeting at the Hotel Astor in New York City, May 20-23. A cordial invitation is extended to all public health nurses.

- The sum of \$1000 was sent to the Finnish Nurses League recently by a small group of American nurses who are acquainted with Finnish nurses. This gift, sent through the Hoover Committee, was given for aid to injured or needy nurses.

- The Catholic University School of Nursing Education is offering a symposium on clinical experience in nursing to be held at the University, June 26 and 27. It is the aim of this symposium to give valuable and practical assistance in the development of desirable clinical experience in medical and surgical nursing. Consideration will be given to the integration of the principles of biological and physical sciences, sociology, psychology, and public health.

The registration fee is \$1.50 and includes the cost of one copy of the proceedings. Advanced registration may be

made at the present time by writing to the secretary, School of Nursing Education, The Catholic University of America, Washington, D.C.

- The American Home Economics Association will hold its annual meeting in Cleveland, Ohio, from June 23 to 27. The Hotel Statler will be headquarters except for student club representatives. Further information may be secured from the Association headquarters, 620 Mills Building, Washington, D.C.

- The sixty-ninth annual meeting of the American Public Health Association will be held at the Book-Cadillac Hotel, Detroit, Mich., October 8-11. The Michigan Public Health Association, the American School Health Association, the International Society of Medical Health Officers, the Association of Women in Public Health, and a number of other allied and related organizations will meet in conjunction with the A.P.H.A.

- The fiftieth annual meeting of The Visiting Nurse Association of Chicago was held on January 24 in the auditorium of the Chicago Historical Society. The report of the president emphasized the interest and loyalty of the contributors, the directorate, and the nursing staff, and stressed the part played by the organization in the history of Chicago over a period of fifty years. Gold pins denoting thirty years of service were presented to Mary E. Westphal, the superintendent, and Carrie Bullock, one of the supervisors. These are the first thirty-year pins to be awarded.

- An open competitive examination for public health nurse, county departments, will be held in New York State on May 4. Nonresidents will be eligible to compete, but preference in certification will be given to legal residents of New York State. For information write Examinations Division, Department of Civil Service, Albany, N. Y.

DIRECTORY OF EXHIBITS

Biennial Convention, Philadelphia, Pa., May 12-18, 1940

**The National Organization
for Public Health Nursing
Public Health Nursing**

**The American Nurses'
Association**

**The National League of
Nursing Education
Nursing Information Bureau**

BOOTHS 1007-1013

American Can Company, 230 Park Avenue, New York, N. Y.

BOOTHS 18 and 19 Convention delegates are invited to call at Booths 18 and 19 where information is available concerning those aspects of commercially canned foods which are of particular interest to the nursing profession. The American Can Company's modern, single-service Paper Milk Container will also be featured.

American College of Physicians and Surgeons, Chicago, Ill.

BOOTH 1003

American Dietetic Association, Chicago, Ill.

BOOTH 1002 a

American Hospital Supply Corporation, Chicago, Ill.

BOOTH 407 If you are interested in the latest advancement in Blood Transfusions and Blood Banking be sure to see the demonstrations of Baxter Transfuso Vacs and Plasma Vacs in Booth 407. American Hospital Supply Corporation's selected specialties include the Vasosclerator for treatment of Peripheral Vascular Disease and the Dickson Paraffin Bath. Take a few minutes to examine these valuable therapeutic devices.

American Journal of Nursing, The, 50 West 50 Street, New York, N. Y.

BOOTH 808 The American Journal of Nursing, official publication of the American Nurses' Association, and the National League of Nursing Education, serves nurses throughout the world. It recognizes the interdependence of all health workers. Many public health nurses call it "indispensable." Call at Booth 808 for one of our handy notebooks.

American Medical Association, Chicago, Ill.

BOOTH 201 At the exhibit of *Hygeia*, the health magazine of the American Medical Association, visitors may examine copies of the magazine and secure helpful slants on the value of *Hygeia* to members of the nursing profession. A special introductory subscription is being offered to visitors.

American Nurses' Association, New York, N. Y.

BOOTHS 1007-1008 The exhibit will consist of posters, reference folders, and printed material concerning activities of the American Nurses' Association. Special charts will show progress made by the A.N.A. in the past ten years. Information of educational interest to private duty nurses will also be on display. Other exhibits will include results of the Studies of Community Nursing Needs and Registry Development, 1934-39; Expansion

of the Eight-hour Schedule for Private Duty and General Staff Nurses.

American Red Cross, Washington, D. C.

BOOTHS 905 and 906 The Red Cross exhibit will be a twenty foot display in photos, text, and color electrically lighted, on the various fields of service in the American Red Cross Nursing Service which are open to the women of the nursing profession.

American Social Hygiene Association, 50 West 50 Street, New York City.

BOOTH 911 Social hygiene working tools for the nurse on the job will be the theme of this year's exhibit. Special materials will be included for the clinic nurse, the school and industrial nurse, and the general public health nurse, suggesting programs, methods, and objectives and counselling as to their uses. In turn it is hoped that nurses will offer their suggestions for preparation of new materials in this field.

Baby Development Clinic, Chicago, Ill.

BOOTH 18

Bard-Parker Company, Inc., Danbury, Conn.

BOOTH 502 Bard-Parker will exhibit the following products at Booth 502: Rib-Back surgical blades; renewable Edge Scissors; Hematological case for obtaining blood samples at the bedside; Ortholator for obtaining accurate dental radiographs; Formaldehyde Germicide and Instrument containers for the rustproof sterilization of surgical instruments.

**Becton, Dickinson and Company, Ruth-
erford, N. J.**

BOOTH 308 At Booth 308, Becton, Dickinson will show a representative line of syringes, needles, medical thermometers, Ace Bandages, Diagnostic items, and Asepto syringes, and in addition will present a demonstration on the making of clinical thermometers. An expert thermometer maker will be in the booth at all times, willing and anxious to show how clinical thermometers are manufactured.

Bisodol Company, The, New Haven, Conn.

BOOTH 305 The Bisodol Company extends a cordial invitation to all attending the Biennial Nursing Convention to visit its exhibit at Booth 305. Our representatives will be glad to discuss with you any question regarding the product and provide you with clinical samples.

Borden Company, The, New York, N. Y.

BOOTH 609 Full information on BIOLAC, the new liquid modified milk for infants, will be available at the Borden Booth 609. Also exhibited will be other Borden products for infant feeding, notably Klim, Dryco, Beta Lactose, Merrell-Soule products, and Borden's Irradiated Evaporated Milks.

PUBLIC HEALTH NURSING

Official Organ of the National Organization for Public Health Nursing, Inc.

Community Nursing Service for All

DR. JONES dropped wearily into his chair. His wife solicitously brought his slippers and waited for him to unload some of the day's problems. "Nurses, nurses!" he exclaimed. "Fourteen agencies distributing nursing service in this town and still one can never find the kind of a nurse the patient needs, when he needs her, at a price he can pay. Look at the Smith's down by the cannery. Their baby has pneumonia, and good nursing care is what he needs—full-time private nurses now, and later visiting nurses who can teach the mother what to do between daily visits. The family can pay something; they can't afford \$12 or \$15 a day. But can I get a nurse at *any* price who will take a home case, who knows how to care for pneumonia, and who likes to nurse children? No! I've called all the registries I know. Even if I find one, where is the money coming from?"

"But money isn't the whole problem. Grandma Brown over on the avenue has had a turn for the worse and her daughter is worn out looking after her. The visiting nurse comes in every day but they also need a motherly woman with some training in simple nursing care to relieve the family. Where shall I find a reliable woman who will see that grandma doesn't get bedsores and who won't give the Brown baby soothing syrup when he cries? Somebody ought to be responsible for training and supervising these subprofessional workers."

Mrs. Jones sighed sympathetically.

"Or take the Martinelli's out by the reservoir. She's going to have her baby at home and she doesn't know the first thing about getting her things ready for confinement. The visiting nurses

don't cover that territory because there's a little welfare society supposed to be doing the work in that area. The welfare society doesn't help with home deliveries. Some dark night I'm going to have to bring a new Martinelli into the world without anything to work with and no nurse to help me."

"Has anybody ever tried," said Mrs. Jones thoughtfully, "really to find out how many and what kind of nurses this community needs? Have the agencies distributing nurses and the people using those nurses ever got together to talk over their problems together? You say you can't get the nurses your patients need. Yet there are many unemployed nurses. What is the matter? It seems to me that everybody has a stake in this—the nurses themselves, the people who use them, the doctors, the agencies.

And so they have! It was in recognition of this fact that the three national nursing organizations¹ appointed the Joint Committee on Community Nursing Service in 1935 to study the whole question of "an adequate community nursing service for all types of needs, available to everyone."² Beginning in January 1936 the Committee employed a full-time executive secretary, Lulu St. Clair, who did the pioneer ploughing in the new venture. She collected information from those communities which were already working toward this goal. Out of their experience and the joint thinking of the national nursing groups the Committee evolved certain general principles and procedures which seem applicable to the development of a community nursing program. The secretary also made a number of community studies upon request, and gave field ad-

visory service, sharing the information she had gathered.

A fundamental principle accepted by the Committee is that there should be community participation in making any community nursing plan. The Committee suggested that a council or committee on community nursing be formed as an initial step in analyzing the community's needs, to "be composed of representatives from all elements in the community interested in nursing."³ The participation of citizens, which the N.O.P.H.N. has found essential to any sound public health nursing service, is implied in this principle.

A next step suggested by the Committee is a study by the community of its own needs and facilities, to serve as a basis for future planning. A Tentative Outline for a Survey of Community Nursing Service was prepared in 1939.

On the basis of the facts ascertained through such a study, a plan can be made to eliminate confusion, fill gaps, and if possible reduce the agencies administering or distributing nursing services to the fewest possible number.

A further step which is visualized is the organization of a community nursing bureau¹ to serve as a central clearing house for all types of nursing services needed in the community. Such a bureau will serve as a reservoir of information on community supply and demand in nursing, and will distribute nursing services not already provided by other agencies. It will concern itself with the quality of service rendered. It will have a budget adequate to provide nursing care for those who cannot pay. Many problems are still to be studied in regard to community nursing bureaus—their

sponsorship, financing, and functions.

In September 1939 the Committee was obliged to discontinue its secretary because of lack of adequate funds. This was a great blow to the entire program, which was just getting well under way. Interest in the field has been stimulated, and numerous problems and inquiries are being received. It is still hoped that funds may be found to resume an active program. In the meantime the work of the Committee is centered at the headquarters of the American Nurses' Association and is being carried forward under the guidance of the three national organizations.

What has evolved out of the committee's work to date which communities can use? First of all, the materials prepared during the secretary's three years of work are available for use. A guide to the formation of a council has been published.³ The survey outline is available for communities which want to study themselves, and assistance can be secured from the three nationals in making the study or at least in interpreting the various parts with which they are respectively concerned. Community nursing councils have been developed in several cities.² An experiment in community nursing service in Northern Dutchess County, New York, was described in *The American Journal of Nursing* for January 1940.

In a democracy we grow up like Topsy. The time comes when our situation becomes so complex that coordinated planning by all groups interested in a given community service is needed. Nursing has arrived at that stage and those in the vanguard of thinking are facing it today.

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Care of Feet in Children

By EMIL D. W. HAUSER, M.D.

Proper shoes and the care of the child's feet from the time he learns to walk will serve as a preventive of foot difficulties in later life

THE FOOT of a child is essentially like that of an adult, but the structures and musculature are not as well developed. The bony structures are laid down in cartilage. The muscles are present but they are soft and tender. There is a longitudinal arch present. The presence of the arch is not apparent since it is disguised by a fat pad which lies beneath the skin and fills the hollow under the arch. The short muscles of the foot on the plantar surface also fill in the space beneath the arch. For this reason it was formerly believed that

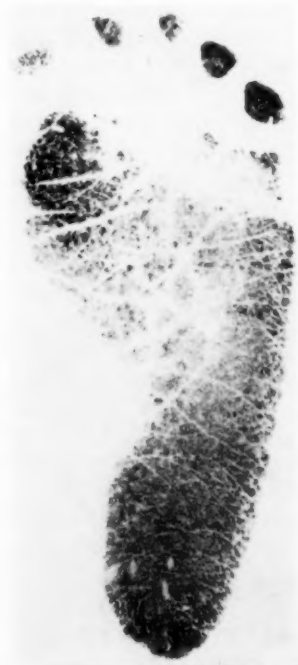


Figure 1
Imprint of the foot of a newborn baby taken with counterpressure equal to the body weight



Figure 2

Longitudinal section of foot and leg of a newborn baby, showing the presence of a longitudinal arch

there was no longitudinal arch present in children. If a footprint is taken with counter-pressure equal to the weight of the child, the print will indicate the presence of an arch. (Fig. 1.) A section through the foot of the infant establishes the presence of a well formed longitudinal arch. (Fig. 2.) There is also present a transverse arch in the



Figure 3

Sketch of a transverse section through the metatarsal bones of a newborn infant, showing the presence of a transverse arch

Metatarsals
(from behind)

anterior part of the foot. (Fig. 3.) The relative height of the arch in a child is slightly less than that of the arch of the adult.

The posterior part of the foot in the child is not so well developed as that of the adult; the calcaneus (heel-bone) projects at a sharper angle in the adult. The anterior part of the foot is proportionately wider in the child than in the adult. The entire foot seems relatively shorter and wider. The great toe shows a greater range of motion in the child's foot than in the adult's. The power of abduction is present in the great toe in early childhood, but is lost in adult life. In early childhood there is present a tendency to walk with the foot inverted, but this is gradually lost as the child grows older. The foot in early childhood is thus softer and more flexible and permits more movement, but it does not have the stability nor the strength of the adult foot.

DEVELOPMENT OF THE FOOT

There is a rapid increase in the length of the foot in early childhood, which is more pronounced in girls. Until about the age of seven the girl's foot is usually longer than the boy's foot. The breadth of the child's foot also increases rapidly. Racial differences are also present; the average Negro child has a longer foot than the average white child of the same age.

The child's foot develops with use. In infancy, normal use consists in wiggling the toes and kicking the feet. Later the child crawls, and this increases the strength of the muscles so that he is able to stand while supporting himself. Gradually muscle balance is acquired until he can retain his equilibrium and stand alone. Then the first steps are taken, with the legs wide apart to give a broader base and more stability. The child walks with the feet turned out and has a gait resembling the rolling gait of the sailor. With practice the balance

improves and the feet are brought in closer together.

The age at which the child starts to walk varies in different individuals. The parents should not urge the child to walk before he is ready, and there is rarely any need for interference by means of mechanical devices to aid him in learning to walk. If he is normal and is permitted to follow his own instincts, he will learn to walk without any mechanical aid or other encouragement. The structures of the foot will develop with physiological use.

INTERFERENCE WITH WALKING

Interference with normal walking is encountered in nearly all children inasmuch as the natural walking surfaces have been altered. They no longer learn to walk on soft ground, but encounter hard walking surfaces almost immediately. The foot must be protected against these surfaces, and it is for this reason that a shoe is necessary.

The shoe for the child should have a pliable leather sole which is thick enough to protect the foot from the pavement. It should fit so that there is no compression of the foot and the toes can move freely. Since the child's foot is naturally soft and tender, the leather covering of the upper part of the shoe should be soft so as not to cause friction. For the infant who has not started to walk—where protection is required against cold and as a hygienic measure only—the sole and upper part of the shoe are of soft material, and loosely fitted. For the child learning to walk, the sole of the shoe is about one eighth of an inch in thickness. (Fig. 4.) This type of shoe should not contain any arch support, nor is a heel necessary. The child's foot should be permitted to act freely, which it can do in such a soft shoe that has sufficient leather sole to protect it against the hard surfaces. High shoes should be worn by the child just learning to walk.

As the child grows older he is on his feet more. If he were to be on soft ground at all times an ordinary moccasin would be ideal. This would be of soft leather to protect the foot against cold, dirt, and moisture, and at the same time would allow the foot to develop normally as was the case with the Indian when he lived in his natural environment. However, with the present walking surfaces a firmer leather sole is necessary. This sole should be about one fourth inch thick the entire length of the shoe. The sole is of leather because it is pliable enough to allow the normal rolling gait and at the same time firm enough to protect the foot. Since it is simpler to carry out normal gait on a hard surface if there is a heel on the shoe, the shoe for this age can have a heel about one fourth inch in height.

For the older child's shoe, the same features hold good as described for the shoe of the younger child, except that it will be more rugged in order to withstand the harder use required of it. The sole will be a little heavier, although still of pliable leather, and the heel may be a little higher. During this growing period again the most important thing

for the shoe is that it allow all normal use of the foot. The shoe may be an Oxford or a high shoe, the climatic conditions being the deciding factor in this case.

Thus the main requirement of a shoe for the infant and for the growing child is that it allows normal development of the foot, and this in turn will insure the development of a good foot.

AVOID INTERFERING WITH FUNCTION

Recently it has been the practice to assume that the child's foot is weak and flat, and for this reason needs support. Consequently a great many shoes have been constructed with arch supports built in, usually in the form of steel within the shank. This metallic support interferes with the normal use of the foot and acts as a preventive of normal development; accordingly it should be avoided.

It is true that at the age of about two years there is usually a period of extraordinarily rapid growth, and for this reason there is often an imbalance between the capacity of the structures and the demand made on them. At this time the strength of the foot may not be



Figure 4
Child's first walking shoe

sufficient to carry the load of the body weight. Such an imbalance will result in an alteration of the position of the bones in relation to each other; the heel turns into valgus (so that the weight is on the inside of the heel) and the tarsal bones are pronated so that the longitudinal arch is lowered. For this reason, shoes for children at this age frequently have a raise on the inner side of the heel along with the built-in arch support. This type of correction, which is in common use, not only has the disadvantage that it throws the heel into varus (with the weight on the outside of the heel); it also puts the anterior part of the foot into supination, since the raise on the inner side of the heel raises the entire length of the foot because of the steel in the shank. Thus, the child walks on the outside of his foot with the inside of the foot raised. This is an abnormal position and does not permit normal gait.

In addition to the fact that such a shoe interferes with the normal rolling gait, it also holds the foot in a position which, if held long enough, becomes fixed and is thus a type of deformity. If the anterior part of the foot is held in supination, when the child walks barefoot it is apparent that in order to place the inside of the anterior part of the foot on the ground the heel first goes into valgus, thus causing a flatfoot. For this reason, the shoe described above has a tendency to convert a normal foot into a flatfoot, and should therefore be avoided.

Interference with normal development of the foot will result in a weak foot and ultimately in a flatfoot. There are other causes of weak feet besides interference with development. A weak foot may be the result of a nutritional disturbance or of prolonged illness, or it may be the result of strain. An acute strain will interfere with normal use and weaken the foot. Chronic strain also weakens the foot. At times an active child may become so interested in play and so

stimulated that he may carry out activity to the extent where strain occurs.

WEAK FOOT

With an imbalance between the capacity of the foot and the demand made upon it, a strain results. Fatigue is a symptom of such a strain. The child tires easily. There is pain. He complains of aches in the muscles of the leg. There may be night cries due to cramps in the legs and thighs. The imbalance between the capacity and the load will lead to an alteration in the relationship of the bones to each other, and this always takes a similar course. The heel goes into valgus, the midtarsal area is pronated, and the anterior part of the foot is supinated, which is the position of a typical pes valgoplanus or flatfoot.

Frequently the child attempts to correct this deformity himself by walking with the foot in the inverted position, in which case the intoeing of the foot is an automatic attempt to correct a weak foot, or it may be the result of the inverted position seen in the newborn. Thus the imbalance results ultimately in a pes valgoplanus. Pes valgoplanus may also be congenital, in some instances due to holding the foot in extreme inversion *in utero*. This deformity must be considered in the same light as the congenital clubfoot. In some instances there is an actual congenital anomaly present which causes the pes valgoplanus. Such a condition is more resistant to treatment.

INTOEING

A common complaint encountered by the public health nurse is intoeing. In the normal child the gradual use of the foot will see a decrease of this intoeing and a gradual reestablishment of normal. Often, however, this intoeing is an overcompensation for a foot strain. In order to prevent pes valgoplanus the child automatically attempts to correct the

deformity by bringing the heel into increased inversion. In these cases relief of the foot strain will bring about correction of the intoeing. The intoeing may also be the result of a congenital deformity, in which case there is some adduction of the foot and occasionally some internal rotation of the tibia. This congenital deformity may be associated with varus and supination of the foot, in which case we have a typical congenital clubfoot. Of course, when such a condition exists orthopedic measures are necessary for its correction.

IMBALANCE NORMAL IN YOUNG CHILD

It is important to be able to recognize the true congenital deformities and true deformities which have been acquired, in order to distinguish them from alterations which are still within the range of normal. The change from the newborn foot to the adult foot is a gradual one. At the age of two, during the rapid growth period, there is always a tendency toward a pes valgoplanus and genu valgum (knock knee) due to the imbalance between the strength of the extremities and the demand made upon them. Since a certain amount of alteration which occurs at the age of two must be considered normal, it is important to recognize the limits beyond which it cannot be considered normal. In this the degree of deformity is important, as is also the age at which the deformity exists.

Even though in most children the rapid growth period is around the age of two, a great many children have a rapid growth period at the age of three or four, or even at five, at which time there will be an imbalance between the strength of the structures and the work required of them. If there is an extreme amount of pes valgoplanus and genu valgum even in the very young child, it will have to be considered abnormal and should have correction. If there is pes valgoplanus or genu valgum present

after the age of six, then it must be considered abnormal and will require correction.

TREATMENT

Special pads within the shoes

Correction of weak foot and flatfoot consists in bringing the heel into varus and the anterior part of the foot into pronation, which is the opposite of the position that is assumed in the case of flatfoot. To accomplish this, a shoe is utilized that is pliable and yet has sufficient leather to support the foot. The author's technique of correction consists of two felt pads placed within the shoe.

One of these pads has an inclined plane directed from the medial to the lateral side. This pad is placed within the shoe with the inclined plane beneath the longitudinal arch. It has a tendency to raise the medial side of the foot and thus force the heel into a varus position.

The other pad has an inclined plane directed from the lateral side toward the medial side. This pad is placed within the shoe beneath the first, second, third, and fourth metatarsal bones, so that it lies immediately posterior or proximal to the heads of these bones. The height of the pad thus lies beneath the head of the third metatarsal bone. In this way the third metatarsal bone is raised higher than the second and fourth, and the second and fourth are higher than the first, which rests on the shoe. In the same way the fifth metatarsal bone rests on the shoe.

The heel is thus in varus and the anterior part of the foot in pronation. This reestablishes the normal longitudinal arch, and since the heads of the fifth and first metatarsal bones are on the same plane, which is lower than the heads of the second, third, and fourth metatarsal bones, there is a reestablishment of the transverse arch. Now the foot is in normal position and the child is able to walk with a normal rolling gait.



Figure 5

Corrective shoe for a child; plantar aspect

Corrections on the outside of the shoe

Another method to accomplish the same thing more effectively is to raise the inner side of the heel of the shoe one eighth inch or one sixth inch, depending upon the amount of correction one wishes to take. The raise of the inner side of the heel of the shoe brings the heel of the foot into varus position. Then, to bring the anterior part of the foot into pronation, a transverse bar is placed on the outer side of the sole of the shoe. This transverse bar lies just posterior to the position that the heads

of the metatarsal bones will take in the shoe. (Fig. 5.) Here again the bar lies beneath the fourth, third, second, and first metatarsal bones; the fifth is not raised. The bar is constructed so that it forms an inclined plane. The lateral side of the bar is one fourth inch higher than the medial side. Thus the anterior part of the foot is brought into pronation. With the heel in varus and the anterior part of the foot in pronation, the arch is again reestablished.

Since the shoe is pliable, the heel can be twisted in one direction and the front part of the foot can be twisted in the opposite direction. The raise on the outside of the shoe has a tendency to force the child to roll over the bar. This rolling over the bar is further encouragement to carry out the normal rolling gait. These corrections will relieve the foot strain and at the same time they will prevent the development of a flatfoot. Furthermore, if a flatfoot is present, the use of the shoes with these corrections will reestablish the foot to normal. The pes valgoplanus will be corrected, and also normal gait will be acquired and normal strength attained. We thus have a mechanism that acts as a preventive as well as a cure.

By means of these corrections the relationship of the bones to each other is reestablished to normal. With the reestablishment of the normal relationship of the bones, normal gait can be carried out. Since the structures will grow according to the way they are used, with normal use there will be a reestablishment of normal structures and the functional capacity will be increased. In other words, the foot will be normal both as to structure and function. Since



Figure 6

Heel-and-toe gait; three phases taken from a rapid photograph of normal walking

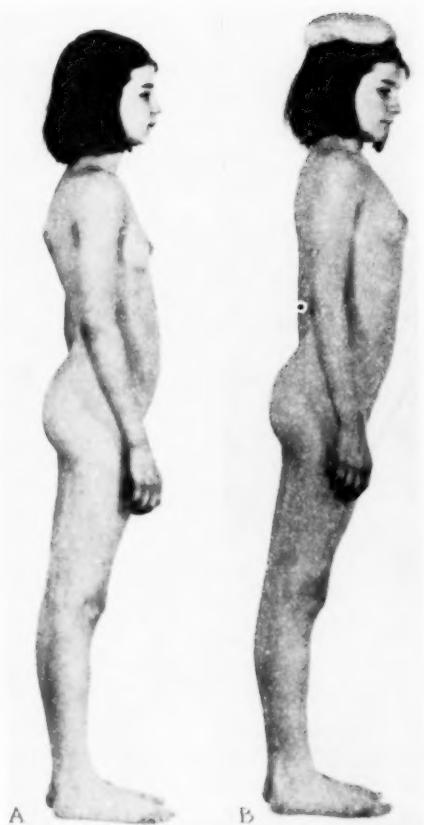


Figure 7

A. Poor posture as seen on first examination
B. Immediate improvement with the application of the sandbag

the development of the structures is dependent on normal use, it is important that the normal function of the foot, or correct gait, be executed.

NORMAL GAIT

Since the primary normal function of the child is walking, it is important that the public health nurse have an understanding of normal gait. In normal walking the foot propels the body forward. The body is held erect by means of the structures of the trunk and the abdominal and back muscles. With the body held erect, one foot is placed forward with the heel on the ground and the toes raised. The foot is in a dorsiflexed position. The weight then rolls

over the heel of this advanced foot and is transmitted onto the toes, while at the same time the heel of the other foot is lifted off the ground. The weight shifts from the heel over the lateral side of the foot, across the anterior part of the foot to the great toe, on the foot that was advanced. There is thus a rolling motion starting at the outside of the heel, over the lateral side of the foot, across the anterior part of the foot and then off the great toe. The heel acts as a lever, and the great toe, with the aid of the other toes, acts as a propulsive force to push the body weight forward. Thus the foot is never flat on the ground, once walking has started. (Fig. 6.) The heel and toe of the same foot are never on the ground at the same time. In this way an arc is formed which can be compared to half a wheel. This rolling motion of the foot propels the body forward in an even manner, provided the erect posture is held. In a normal child, where there is no interference with the normal use of the foot, such a gait develops naturally.

In older children, however, where a flatfoot gait has been established, the habit must be altered. In walking flat-footed the child has a tendency to turn out the toes and shift his weight from one foot to the other, with the body sagging. Since this movement has become automatic it is necessary not only to permit normal gait, but also to teach the child how to walk normally. The best method for teaching children is by imitation.

The author usually has the child walk, and then imitates his abnormal gait. Then to demonstrate this gait further, the abnormal gait is exaggerated. Next, normal gait is demonstrated and an exaggeration of the normal gait is carried out. The best exercise to learn normal walking is for the child to exaggerate normal gait. The attempts of the child to exaggerate the gait will require sufficient correction so that it probably will

reach what one might consider normal. And since an exaggeration would require a conscious effort it is usually best to have the child practice this gait at home. The practice is carried out at first for short periods, five minutes at a time, and later increased to fifteen and then to thirty minutes at a time. Soon the child can walk without feeling conscious of an exaggeration that would be apparent, and the automatic gait is definitely improved. The exaggeration of normal gait is continued until the automatic gait has been reestablished to normal.

An excellent means for acquiring good carriage during the reestablishment of normal gait is to balance a weight on the head. For this purpose the author uses a sandbag. (Fig. 7.) The optimal position of the body is obtained when a weight is balanced on the head, as is demonstrated by the natives in the coun-

tries where it is customary to carry heavy burdens on their heads. When normal gait has been learned the child is carrying out normal function, and when the foot carries out its normal function it will also resume its normal anatomic relationship and thus be reestablished to normal appearance.

The prevention and correction of a deformity in a child acts as a prophylaxis against further development of the deformity in an adult. The formation of correct habits with regard to posture and normal gait in childhood will influence the development of the adult, and in this way the habits of childhood can be used as a prophylaxis against foot disorders in the adult.

NOTE: All illustrations except Figure 4 are reproduced from *Diseases of the Foot*, by Emil D. W. Hauser, W. B. Saunders Company, Philadelphia.

THE VALUE OF WHEAT GERM

WHEN white flour and white cereals are prepared, the germ and bran are removed, and with them go most of the iron and vitamins B and G of the grain. These vitamins are necessary to protect the nervous system, to regulate digestion, and to "preserve the characteristics of youth."

Recently, wheat germ with its rich content of vitamins B and G has been made available on the market at prices ranging from 25 cents to \$1 a pound. It may be necessary to buy it in five-pound lots, and direct from the mill, to benefit by the lower price. That sold at the higher price will probably be vacuum-packed in a tin container. At a price somewhere between this high and low, wheat germ is available by the pound in cellophane packages.

For many people, two or three table-

spoons of wheat germ each day would be a valuable addition to the diet, since it is a natural food source of vitamins B and G. It is especially valuable for those who do not eat much bread and cereals—a common practice among adults, particularly sedentary workers. Without these foods of the whole-grain variety, the diet is likely to be low in vitamin B, and some rich source, such as wheat germ, is needed to make up an adequate supply.

Wheat germ, which is flaky or granular, and nonirritating, should not be confused with coarse wheat bran, which has for many years been refined, packaged, and marketed as a breakfast food. Bran may be helpful in some cases of constipation, but its coarseness makes it really harmful in other cases. There is no such danger from wheat germ.

—*Nutrition Notes*, January 1940

Democracy at Work in Parent Education

By ETHEL HEDRICK AND GENEVIEVE R. SOLLER, R.N.

Coöperative planning of parents and school personnel is the basis of this school's educational program to help parents with their problems and needs

SUPPOSE you were a parent of a child just beginning his kindergarten experience. Would you not want to meet occasionally with representatives of the school and consider with them the joint responsibility for the health and welfare of your child? We believe that most parents are interested. No one group has a monopoly of responsibility for children's health, whether it be mental or physical. Improvement in child health will come only from the joint effort of many groups. Today progressive educators must possess the ability to work coöperatively with all community groups, including the home, for the common good of each child entrusted to them.

It has been the custom in the Philip Bach School of Ann Arbor, Michigan, to invite parents of kindergarten children to an informal tea early in September, for the purpose of meeting the school physician, nurse, dental hygienist, principal, psychologist, and kindergarten teacher. This plan has developed many favorable attitudes on the part of parents, but it has been inadequate to meet their many needs and problems.

The parents are largely of German descent and belong to the average income group. Only a very few families are on direct relief. They are thrifty, coöperative, socially minded, and very much interested in the school activities of their children.

A proposal was made last year to extend this one meeting of kindergarten parents to a series of informal meetings

which would be led by the school health personnel, the school psychologist, and representatives of other agencies within the community.

PLANS MADE IN THE SPRING

Tentative plans for these meetings were made coöperatively in May 1939, by the president of the Parent-Teacher Association, the chairman of the kindergarten room group, a mother of an incoming kindergarten child, the kindergarten teacher, the principal, and the school health and child-guidance personnel.

The parents were most enthusiastic about the proposed program. "Why haven't we done this before?" said the chairman of the room group, whose child was completing his kindergarten year.

Since the coöperation of parents and teachers in this program of education was particularly desired, it was decided to submit this tentative outline to a meeting of room group chairmen and teachers early in September. This group of community leaders could then evaluate the program in the light of their needs and recommend changes and points of emphasis. It is only through such coöperative planning and participation that a program may become effective.

The first meeting of the new kindergarten room group was held early in September. The tea was planned and served by a committee of parents. The purposes of this meeting were: (1) to provide an opportunity for parents to

become acquainted with the school and with other parents of the five-year-olds (2) to provide an opportunity to outline the program. Mimeographed copies of the program and a bibliography were distributed. The program and educational tools are outlined here.

PROGRAM AND TOOLS

1. Physical factors influencing the health of the kindergarten child: Nutrition and eating habits; elimination; sleep and rest; exercise and play; clothing and cleanliness—by the school nurse.

Tools: posters and charts on food; graphs showing divisions of a child's day; exhibit of suitable clothing and shoes; exhibit of books and pamphlets (from the bibliography).

2. The physical examination of a five-year-old, a wholesome educational experience for the parent as well as the child—by the school physician.

Tools: clinical examination of a child; parent participation.

3. Dentition and factors influencing dentition—by the dental hygienist.

Tools: dental inspection of a child; models of teeth; dentifrices and brushes.

4. Communicable Disease Control: isolation and immunization—by the school physician.

5. Emotional factors influencing the adjustment of the child—by the children's consultant.

Measuring mental growth—by the psychologist.

Tools: exhibit of tests.

6. Round table.

Tools: questions submitted by parents.

Other phases of education provided by the school for parents of five-year-olds are as follows:

1. Education of parents at the school examination

The parents are invited to be present at the examination of their children in the school. This is made an educational experience for the pupil and the parent, as was demonstrated to the mothers of the kindergarten group.

2. Education of parents through conferences in the school

Parent education is further extended through parent-nurse conferences, parent-teacher-nurse conferences, and parent-nurse-principal conferences. Parents

may come to school for these conferences, either through invitation or on their own initiative. Health needs and other problems are discussed, away from the interruptions in the home. The whole attention of the parent is thus secured. In spite of the fact that the conference type of education is time-consuming, it does aid in problem-solving and establishes a better understanding between the home and the school. However important this conference may be, it cannot take the place of the home visit.

3. Education of parents in the home

Due to the economic pressure of recent years many women have secured work outside the home in order to increase the family budget. This means that many parents are unable to participate in any form of parent education carried on during working hours. Some parents are indifferent to all invitations to come to school, while some have responsibilities which prohibit their coming. If these parents are reached at all, education must be extended into the home. Therefore, the home call is the most potent tool possessed by the nurse. The objectives of home visits by the nurse have been summarized as follows:

Home calls have three immediate purposes: self-information or what the nurse learns; health service or what the nurse does; and health education or what the family learns. The remoter purposes are health promotion and disease prevention.*

Time is needed for the nurse to observe and secure information concerning the family pattern, health attitudes, health behavior, as well as the social and economic status of the family. This information should be evaluated and recorded. It should become the basis for a conference between the nurse and school personnel, and should aid the kindergarten teacher in better understanding the five-year-old.

* Chayer, Mary Ella. *School Nursing*. G. P. Putnam's Sons, New York, 1937, p. 246.

MEASURING EFFECTIVENESS

It is difficult to measure the results of any health-education program, particularly over such a short period of time. However, there are certain tangible results of this program of parent education which may be presented for evaluation.

The attendance at meetings increased from about 35 percent of the kindergarten parent group at the first meeting to about 65 percent at the last meeting.

Parent interest increased from meeting to meeting, as was evidenced by the number of questions asked, the keen, informal discussions that followed each meeting, and the requests for literature. Actual questions asked by parents or submitted in writing at the round table have been filed to be used as the basis for future program-building.

The following are actual questions submitted at the round table:

1. Many of us have older children. What amount of sleep should be insisted upon for the nine-year-old? The eleven-year-old?
2. My children do not like liver. Are there other foods which can be substituted to provide as much iron?
3. What foods stimulate a child's appetite?
4. Does playing with toy guns have a tendency to make bad boys?
5. Is canned milk as good for children as fresh milk?
6. Is raw milk from a farm as good as bottled milk from a milk man?
7. When there are two or more children, should each get the same amount of money for his weekly allowance?
8. Do you advise filling baby teeth?
9. Does spanking break a child's spirit?
10. If a vaccination does not take, what should be done?
11. How often should we take our children to the doctor for a physical examination?

An increased number of children have been examined by the family physician and family dentist. During the school year 1938-1939 approximately 25 percent of the children in the kindergarten were examined by their family physicians. This percentage has been in-

creased to 51 percent during the year 1939-1940.

An increased number of children have been protected against diphtheria and smallpox.

There was an increased interest in the control of communicable diseases on the part of parents, as evidenced by the voluntary isolation of their children. In addition, parents are increasingly co-operative in notifying the kindergarten teacher regarding the cause of absence.

RECOMMENDATIONS OF PARENTS

The parents of these five-year-olds recommended:

That a similar series of meetings be held for parents of kindergarten children each year.

That the meetings be extended over a greater period of time.

That more of the meetings be held in the evening to enable working mothers and fathers to attend.

That meetings be planned to include other agencies interested in child health and welfare.

That meetings with this group of parents be continued each year as their children progress from grade to grade and as the school program introduces major changes.

In grade one, the children experience teacher health inspection and this program may be explained and demonstrated to the parents.

Eye tests and hearing tests are given in grade two.

Separate gymnasium classes for boys and girls are begun in grade four, and the program includes showers and footbaths. These frequently are questioned by parents. An understanding of the objectives of the physical-education program may eliminate these objections.

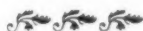
Parents may well expect the school to provide health education for them as well as for their children through a special program of parent education. The rapid advances in the science of medicine and disease prevention challenge educators to keep parents informed of

these changes and to acquaint them with the health facilities of the community.

In this program for parent education specific problems were found. The participating parents came from all population groups, with all kinds of educational backgrounds, with biases, and with a variety of abilities. They par-

ticipated in these meetings because there was a common interest in the welfare of the whole child.

It is believed that parent interest and coöperation in the school program may be maintained if there is a paralleling of parent education with each new phase of the program.



S.O.P.H.N. Convention Dinner

THE GREEN ROOM of the Hotel Bellevue-Stratford will be the scene of the S.O.P.H.N. dinner at the Biennial Convention on Tuesday, May 14, at 7:00 p.m. Attendance will be limited to delegates from the state branches of the National Organization for Public Health Nursing and board and staff members of the N.O.P.H.N. Because of limitations in seating capacity, not more than three or at most four representatives from each branch can be included. It is hoped that every branch will have a non-nurse representative.

As usual, response to roll call will take the form of brief reports from the branches of the outstanding achievements during the past two years and of any steps taken to put into effect recommendations of the Council of Branches at its January meeting. There will be some Council business to transact, since it seems necessary for the Council to adopt simple rules or bylaws to guide its future procedure, but most of the evening

will be devoted to the reports and to informal discussion.

The Pennsylvania State Organization for Public Health Nursing—whose president is Mathilda Scheuer, newly elected vice-chairman of the Council of Branches—will act as hostesses. They are making plans for special music and other entertainment.

Dinner dresses will be in order, but no one need stay at home because she forgot to bring an evening dress. Every branch is urged to make sure it is well represented at the dinner, which will offer an opportunity to compare notes and to get acquainted as well as to relax from the week's strenuous activities.

The dinner will be \$2.25 a plate, and reservations should be made at least twenty-four hours in advance at the table provided for that purpose near the registration booth. If more than four members from one branch wish to attend they may make tentative reservations. Insofar as the size of the room permits, all S.O.P.H.N. members will be included.

The Classification of Positions

BY ISMAR BARUCH

A discussion of the basis and methods of position-classification under the merit system and its effective use as a modern tool of personnel administration

THE GROWTH in the magnitude and complexity of governmental services, the importance of personnel in the operations of government, and the unique responsibility of government to the people in general and to the taxpayers in particular are factors which have led to common agreement that personnel administration in government should be conducted on a planned and scientific basis. This means that a public personnel program not only should be based on sound policies and objectives but also should be carried out through modern methods and procedures, or tools of administration.

Position-classification is one of these modern tools of personnel administration.* Its immediate objective is to organize facts about the duties and responsibilities of individual positions in such a way as to permit administrative, personnel, and fiscal authorities to deal with positions in groups, or "classes of positions," instead of singly.

DEFINING CLASSES OF POSITIONS

If all individual positions in a state or city have to be studied as separate entities every time that a personnel policy has to be enunciated, an administrative problem solved, a position filled, a personnel procedure applied, or pay rates determined, a confused and inefficient

situation results which is unsatisfactory to legislators, administrators, employees, and the public. Position-classification avoids this result by indicating (1) which positions are sufficiently alike to be treated alike in personnel and fiscal matters (2) which are sufficiently different to require different treatment, and to what degree they are different. It thus aids in achieving equity and coordination in the treatment of positions and the employees occupying them.

WHAT IS A "POSITION"

A *position* in personnel administration is composed of assignments of work and delegations of accompanying responsibilities requiring the services of one employee. It may be part time or full time, occupied or vacant, temporary or permanent.

At any given time a position is characterized by its duties and responsibilities as they exist at that time. So long as these attributes remain the same, the position itself remains the same regardless of any other considerations. The duties and responsibilities of a position are, however, not always fixed and immutable. They may change from time to time, abruptly or gradually, and because of any one of a number of different reasons.

Since a position is characterized by its *current* duties and responsibilities it follows that when these change in some material respect, the position itself changes. It is not the same position it

*Position-classification as used here should be distinguished from the process of placing positions under a merit system, which is frequently spoken of as putting the positions in the "classified" service.

was before. A new position is created, different to the extent of the change from the old one.

BASIS OF CLASSIFICATION

The process of classification consists of placing things in classes. We place in the same class the things that are alike in a certain respect, and we place in different classes the things that are different in this respect. The attribute we choose as a basis for distinguishing between likeness and difference is commonly spoken of as the *basis* of the classification.

In order to classify any aggregation of things, we must decide beforehand what the basis of the classification will be. But since most things are alike or different in *more* than one respect, they generally lend themselves to classification on more than one basis. The selection of the basis to be employed depends on the purpose of the classification and the uses to which it will be put.

In selecting a basis for classifying positions, we desire our end-result to be a classification plan that will serve as a facilitating instrument for personnel administration, particularly in such processes as the establishing of qualification requirements for positions, the actual recruiting and testing processes, the in-service transactions involved in the maintenance of effective working forces, and the determination of pay scales.

UNDERLYING PRINCIPLES

Underlying these processes there is a broad prerequisite for equitable and effective operation which may be expressed simply as follows: Positions involving the same kind and level of work should carry the same qualification requirements and (under the same working conditions) the same scale of pay. As a corollary, differences in the work of various positions, either in kind or level or both, should be reflected by corresponding differences in scales of pay

and qualification requirements. In other words, for the effective conduct of personnel administration there must be a logical and consistent relation among three things: (1) the duties and responsibilities of positions (2) the qualifications required to fill them (3) the pay scales established for the performance of these duties and responsibilities.

The relationship between these three things can be secured for any *one* position by making the qualification requirements and the pay scale both depend on the character, difficulty, and responsibility of the work involved in that position. However, when we wish to accomplish the same result for a number of positions—some of which are alike and some different—we need (1) to identify and group together in one class all positions which involve work sufficiently similar to call for the same pay scale and the same tests of knowledge and ability and other qualification requirements (2) to determine the direction and magnitude of differences among these classes. These are the essential processes of position-classification.

We adopt the work of each position as the basis for its classification, place in the same class those positions involving work sufficiently similar to warrant like treatment, and arrange all the classes of positions according to kind of work and level of difficulty and responsibility so as to show how each class of positions is related to all the other classes in these respects. For identification purposes, each class is given an appropriate class name or title, such as "orthopedic public health nurse," and is defined and described by a *class specification* in terms of work and qualification requirements.

Positions that fall in the same class are designated by the class name. They are filled by using the same qualification requirements and test standards, and paid (under the same working conditions) according to the pay scale for the class. Moreover, since the various

classes are arranged in order of their difficulty and responsibility, qualification requirements and pay scales may be developed so as to ascend or descend in quality and amount in such a way that differences in the work of the positions are properly reflected by corresponding differences in qualification requirements and pay scales.

TOOL OF WIDE USEFULNESS

This feature of position-classification makes it an administrative tool of wide usefulness. It groups individual positions into classes of positions on a basis that has real meaning in personnel administration. By emphasizing an impartial scientific approach, it helps avoid a purely personal treatment of work and pay problems. It aids recruiting and testing authorities by making it possible to hold tests for classes of positions instead of a larger number of tests for individual positions having immaterial differences, and by furnishing for each class a picture of the work to be performed and a statement of qualification requirements.

In its use as a sound basis for a fairly administered pay plan, it serves the interests of the people, the taxpayers, the operating officials, and the employees. Its system of class titles constitutes a uniform job language defined in class specifications, which provides a base for common understanding among all those agencies and officials having to do with personnel administration. It facilitates the preparation of budgets; clarifies promotions and transfers; aids in developing service rating plans and training programs; aids in planning and improving organization; promotes good employee-management relations; and makes it possible to keep significant service records and compile meaningful personnel statistics.

METHODS OF CLASSIFICATION

Methods of position-classification naturally divide themselves into two broad

groups: (1) developing and installing a position-classification plan for the first time (2) maintaining or administering it after it has been put into effect.

DEVELOPING A PLAN

The outstanding procedures in the development of a classification plan for positions are:

1. Making a thorough and comprehensive fact-finding survey of the positions in the jurisdiction.
2. Analyzing their duties and responsibilities, and the qualifications needed in each position.
3. Establishing an arrangement of classes of positions, under which each class is composed of all positions that are sufficiently alike in duties, responsibilities, and qualification requirements to warrant like treatment in applying personnel policies, and in carrying out recruiting, testing, and other personnel procedures, and under which the relative rank of each of such classes, particularly those in the same occupation or field of work, is clearly indicated.
4. Designating each such class by an appropriate official name or title.
5. Defining or describing each such class, and consequently each class title, by a written statement of the duties, responsibilities, and qualification requirements of the class. This is known as a "class specification." The class specifications collectively show all the distinguishing characteristics among positions (in subject matter, field of work, function, or process, as well as in importance, difficulty, and responsibility) that are considered by administrators in deciding broad problems of personnel policy and in applying policies to individual cases.
6. Allocating each individual position to its appropriate class of the classification system, giving each position the title of its class.
7. Establishing procedures for the installation and maintenance of the classification plan and for the interpretation, amendment, and alteration of the classes and the class specifications.
8. Placing the responsibility for installing and maintaining the classification plan upon some executive agency which, in order to carry out this responsibility, has been given corresponding authority.

Some of these processes will be briefly discussed here.

Obviously, in order to work out a plan under which positions can be consistently classified on the basis of their duties and

responsibilities, we must know in considerable detail what these are. We also need to know much about the setting in which the positions exist, and therefore, facts about the organization and functions of the operating departments also have to be secured.

STUDYING THE POSITIONS

To ascertain the facts about the work of each position the best sources of information embrace the employee who is doing that work and one or more of his supervisors who are responsible for seeing that it is done effectively. The possible methods of reaching these informants include (1) personal interviews and observation of the work by a trained analyst (2) the use of questionnaires (3) a combination of these two methods. The decision as to which method will be adopted on an original survey depends on cost, time, and general practicability. Usually the third device, involving a combination of interview and questionnaire methods, is used.

Questionnaires are distributed through official channels to the employees whose positions are to be covered. They are filled out by the employees themselves; reviewed, checked, amplified, or corrected by their supervisors; certified by some responsible official as being substantially correct; and forwarded to the classifying agency. These questionnaires form the basis for the study of positions by the classification staff, supplemented by interview or observation techniques applied to sample positions, key types of positions, and cases or problems demanding special inquiry.

ESTABLISHING THE CLASSES

The most important problem faced by the classification staff is the recognition of the different kinds and levels of positions that exist in the service, or, more technically speaking, the recognition of classes of positions.

The classes into which the existing

positions fall are identified through an exploration of their similarities and divergencies, both as to kind of work and level of difficulty and responsibility. The establishing of classes calls for sound judgment in personnel matters based (1) on the basic concept of a *class* of positions as described earlier in this article (2) on the purpose of a position-classification plan as a facilitating instrument for personnel administration.

In determining whether two positions are sufficiently similar to fall in the same class, it is necessary to consider the propriety of using: (1) the same title (2) the same qualification requirements (3) the same tests of fitness (4) the same pay scale (under the same working conditions) for all positions in the class. In actual practice the degree of refinement of classification is determined by the working advantages to be gained, and consequently, distinctions which are immaterial for purposes of personnel administration are ignored.

GIVING CLASS A DESCRIPTIVE NAME

The title selected for each class is intended to comprise the name of the class, the official name of each position allocated to the class, and the official title of the employee for purposes of employment, appropriation, payroll, and budget while he is occupying a position in the class. This does not, however, preclude the use of operating titles or organizational titles in connection with departmental activities or outside contacts.

PREPARING CLASS SPECIFICATIONS

Class specifications describe the boundaries of the classes in terms of duties and responsibilities, illustrative examples of work performed, and knowledges, abilities, and other qualification requirements. Their objectives, among other things, are to serve as a convenient, current record identifying the characteristics of any class for any purpose. They permit the effective use of the position-

classification plan, its classes and class titles, and its arrangement of classes, by all concerned in personnel administration.

MUST BE KEPT UP TO DATE

No matter how sound and consistent any classification of positions may be at the time it is originally prepared, it will not put itself into effect nor apply itself in future operation. Neither will it continue to fit the service indefinitely into the future. The service itself is not a static structure but a changing one in which work units are reorganized, tasks are redistributed among groups of employees, responsibilities grow or decline, and positions are changed, abolished, and created. The classes and the allocations of positions based on the service as it exists at any given time must, therefore, be changed currently to keep in touch with the way in which the service itself and its position content have changed.

Unless such changes as they occur are

recognized in the current allocations of positions to classes and in necessary amendments of the classification plan itself, eventually the plan will be obsolete. It will fail to fit positions in the service as they actually exist, and will lack utility as an administrative tool. Day-by-day continuity in keeping a plan current is essential.

To achieve this continuity, there should be established an adequately staffed classifying agency. Such an agency's work will embrace the following functions: keeping constantly informed of the current duties and responsibilities of positions; making changes in classes, class specifications, and allocations of positions to classes, as may be required to keep them matched with the facts; and in general, exercising a coordinating control over the plan and its application. Such an agency is particularly necessary to maintain a unified point of view from division to division, from bureau to bureau, and from department to department.



ADDITIONAL SUMMER COURSES

Kentucky

***Lexington. University of Kentucky.** First term—June 17-July 20. Second term—July 22-August 24. Courses in public health nursing, county health practice for nurses, public health, maternal and child health, health education and health supervision of schools, mental hygiene, elementary psychology, sociology, social work, bacteriology, and chemistry. For further information write to Dr. Jesse E. Adams, director of the Summer Session, University of Kentucky, Lexington.

Wisconsin

****Milwaukee. Marquette University.** June 24-August 2. Courses in principles and problems of public health nursing; field work in public health and social case-work agencies, and in nursing education. For further information write to Sister M. Berenice, College of Nursing, Marquette University, 3058 North 51 Street, Milwaukee.

*These courses are a part of curricula which have not been evaluated by the National Organization for Public Health Nursing.

**These courses are a part of a program of study which has been evaluated by the N.O.P.H.N. A list of summer courses appeared in the April issue, page 254.

The Mores of Pregnancy

By LEONA BAUMGARTNER, M.D., Ph.D.

Suggestions for a maternity-education program are found in studies of primitive society and in surveys of the knowledge and attitudes of our own communities

IN NEW GUINEA there are a gentle mountain-dwelling folk known as the Arapesh, among whom pregnancy is fashionable, morning sickness is practically unknown, and labor pains are not dreaded. Close by is another tribe, the Mundugumors, among whom morning sickness does occur, infanticide and abortion are very common, and the maternal death rate is unusually high. The striking difference between these two peoples seems to be sufficiently arresting to warrant a more careful examination of their societies. Thanks to the work of modern anthropologists we have a fairly good picture of them.

These investigators have circled the globe studying various primitive societies in their efforts to understand modern civilization. One of the principles upon which their studies are based is that societies may be standardized in one direction or in another; that the culture may be skewed so that emotional attitudes, beliefs, and behaviors are altered.

In the words of one of the most widely known of the modern school, Dr. Margaret Mead:

When we study the simpler societies, we cannot but be impressed with the many ways in which man has taken a few hints and woven them into the beautiful imaginative social fabrics that we call civilization . . . man [has] made for himself a fabric of culture within which each human life was dignified by form and meaning. Man became not merely one of the beasts that mated, fought for its food, and died, but a human being with a name, a position, and a God. Each people makes this fabric differently, selects some clues and

ignores others, emphasizes a different sector of the whole arc of human potentialities.¹

It was with this point of view that Dr. Mead began her study of the two tribes in New Guinea. The Arapesh have developed a highly coöperative society. Their life is organized around "this central plot of the way men and women unite in a common adventure that is primarily oriented away from the self towards the needs of the next generation."² Attentiveness to others and responsiveness to the concern of others are the common motivations upon which their society works. For example, a man plants coconut trees not for himself but for his sons. Here pregnancy is a serious business, one at which both mother and father must work, for the procreative task of the Arapesh father is not completed with impregnation. When the first menstrual period is missed, both mother and father attack seriously the problem of making a healthy child. The mother eats special food and the father also has his particular tasks. Both parents observe taboos, gladly, to protect the unborn child. After the birth of the baby, their lives are arranged in terms of his welfare until he is able to walk.

Here pregnancy is desirable and fashionable. Adolescent girls long for pen-

¹ Mead, Margaret. *Sex and Temperament in Three Primitive Societies*. William Morrow and Company, New York, 1935, p. xiii.

² *Ibid.*

dulous breasts. This is the society in which morning sickness is almost unknown. The rare case is only an accident. No one believes it will happen again—and it does not.

In sharp contrast is another tribe, the Mundugumors—a warring, aggressive people who live a scant hundred miles away from the Arapesh. Here there is no genuine community. Social organization is based upon a theory of natural hostility between all members of the same sex. The successful man is the one who has succeeded in getting the largest number of wives. Fathers and sons are rivals. When a Mundugumor woman tells her husband she is pregnant, he is not pleased. He usually interprets it to mean that she has been unfaithful. He curses the antipregnancy magic he invoked in vain. The woman associates her pregnancy with her husband's anger and the fact that he will probably take another wife. There is nothing but unpleasantness in the whole affair, and in this society Dr. Mead found a high maternal death rate, with morning nausea, infanticide, and abortion very common.

Comparisons may not be valid, but it is interesting to consider what seems to be the attitude toward pregnancy in our modern culture. In the first place, whether a family does or does not want children, it certainly is fashionable to "behave non-pregnant" as long as possible. Maternity clothes are not worn until they must be. Probably no one but the wife's mother and husband knows of the pregnancy until after the fifth month. The golfing mother often plays golf even more actively. Certainly every attempt is made to disguise the fact of pregnancy. The mother who has a job fears that her pregnancy will bring dismissal, even though medically there is no reason why she should not continue to work. Does this mean that we believe pregnancy is disfiguring, uncomfortable, and perhaps painful?

Suppose we were to make pregnancy fashionable—not fashionable in the sense of rearing children to furnish manpower for the state, but fashionable in the sense that a new prestige for pregnancy was created; that pregnancy was greeted with joy and pride; that one "acted pregnant" as soon as one became so. To seek medical care as soon as possible might then become the accepted thing to do. Under these circumstances, Mrs. Jones would say to her neighbor, "Oh, how nice! You are pregnant. And who is your doctor?" She would raise an eyebrow when unfashionable Mrs. Smith admitted she was probably four weeks pregnant but had not yet chosen her doctor. In other words, may it not be possible that our emotional attitudes and our folklore concerning pregnancy have a very direct bearing on our behavior during pregnancy? This is at least the inference one can draw from the studies of primitive societies. And the health educator may need to examine carefully these mores of modern pregnancy, before he draws up his educational campaign.

FATHER IS NEGLECTED

The part which the father plays in pregnancy is usually neglected in our society. We may have something to learn from the Arapesh where the father and mother play an almost equal part in various activities demanded of prospective parents by the social customs of the tribe. Do we shut our fathers out of the picture so that many of them do not even feel the baby is theirs until a year or so after birth? The recent experience of the Maternity Center Association proves that fathers' classes can be as helpful, lively, and appealing as mothers' classes, and that fathers want to know more about pregnancy and participate more actively in caring for their newborn babies.

Are we also neglecting the adolescent girl? In almost all primitive societies

there are elaborate rites by which the status of the adolescent is established, and often further rites for adulthood. Almost universally, adolescents, if not younger children, know about pregnancy and birth. Often they have seen several deliveries. Apparently these elaborate preparations for parenthood dispel fears and create a wholesome attitude toward future responsibilities. In our society we have, on the other hand, withheld information from our adolescents and our children. The present confusion among the leaders who have sponsored sex education during the past two decades indicates how carefully we need to examine the method of giving our children information concerning sex and the reproduction processes.

DOES KNOWLEDGE RESULT IN ACTION?

The effective health education campaign must precipitate action—not merely spread information or create attitudes. Social psychologists have shown us that knowledge alone does not necessarily alter behavior. The health educator, faced with the problem of getting more women under better medical care during pregnancy, must not only take into account the body of fundamental information concerning pregnancy which he is trying to sell to the group. He must also cope with the diversity of emotional attitudes toward pregnancy which that group may display, and must determine what specific action he is trying to produce.

It is this approach which has determined some of the activities in a recent survey made by the District Health Education Demonstration in the Kips Bay-Yorkville Health Center of New York City. A campaign was to be undertaken to get mothers under care early in pregnancy. It was found that 90 percent of the women in the area were delivered in hospitals, but that half of the women did not seek medical advice until the seventh month of pregnancy

or after. Several explanations were possible and it seemed wise to know before beginning a health education campaign, which was correct.

Did women know that medical care was necessary?

Did they know when they should go to the doctor?

Did they believe in educating pregnant mothers about the care of infants and themselves?

Did they believe prenatal medical care was necessary in each pregnancy or just the first?

Did they know the cost of such care or how to get it?

Did the husbands who paid the bills know these things too?

The staff³ decided to get answers to these questions before they started a campaign. They adopted methods of determining public opinion similar to those used by George Gallup and various advertising agencies. They then knew what was the status of understanding of the principles of good antepartum care by the people living in that district. This was not information derived from patients receiving such care but from a cross section of the district population, suitably weighted in accordance with their racial and economic characteristics. An unemployed Polish laborer, a debutante, a waitress, an Austrian grandmother, a bachelor stockbroker—all contributed. For example, three quarters of these people knew that a woman should be under a doctor's care by the time her third month of pregnancy begins, and 81% believed that mothers should be trained for pregnancy through antepartum education. Three quarters believed that visits to the doctors should be frequent or regular. Only 65 percent knew whether charges for maternal care were made by the case or for each visit, and 53 percent believed that women disliked going to hospitals to be examined when they expected a baby.

Here was the basis for a different kind of educational campaign. It was not

³Under the direction of Philip Broughton and Paul Guernsey.

necessary to sell the idea of the value of antepartum care. That was known by an estimated 150,000 to 165,000 of the 200,000 people living in the area. It was obvious that to get at the heart of the problem the health educator would have to determine how to convert the accepted beliefs into action. If 75 percent of the people believe in antepartum care by the third month, why do only 9 percent secure it? What are the reasons for this wide difference between practice and belief?

This is not a problem which is easily solved, but in the meantime the health educator had valuable leads for his campaign. He need not emphasize factual information about the processes of the human body and the methods of and reasons for antepartum care. He must instead outline the steps by which one gets under care by the third month. To his surprise he found that none of the literature he was distributing featured this point!

It was evident that doctors and hospitals should let patients know the exact terms under which they may secure antepartum care, instead of merely urging mothers to seek medical care when pregnant. Perhaps they needed also to discover what practices in their clinics and offices made women dislike examination so much. Had health educators created a picture of a friendly, helpful service which the patient did not find when she sought it? Or had they created a demand for services which could not be met? Inquiry revealed that there were sufficient resources so that every woman in the district could receive good antepartum care. The job was not one of creating a demand for services but one of correlating the services with the educational program. Here, then, is an educational campaign based on the knowledge about maternal care among those who are and who are not making use of the services, a campaign which has attempted to ascertain certain emo-

tional attitudes towards pregnancy and has thus armed itself to direct its program.

However, we must not imagine that such health education campaigns can be undertaken without time, energy, and money. No business house gets results from an advertising campaign without spending time and money. But how often the health officer squeezes in the maternal health education campaign as an odd job!

DO WE USE EFFECTIVE APPEAL?

One additional question may be raised. Are our maternal health campaigns utilizing the most effective appeal to the public? Usually we plead that we must save the lives of those mothers who die unnecessarily in childbirth, or we point with shame to the fact that the maternal death rate in our town is twice what experts say it should be. But does this stir Mrs. Jones to action when she is pregnant? Isn't she more interested in the joy of having her own baby as healthy as possible when he is born, and in the security of having her baby as safely, easily, and cheaply as possible? Would not an individual appeal on this level yield greater results than the impersonal one to the group, based on fear?

SUMMARY

1. Our emotional attitudes toward pregnancy help to determine our behavior during pregnancy. The health educator must consider these as well as the factual information he wishes his public to know. Perhaps he needs also to create a new prestige for pregnancy.

2. Educational campaigns need to be directed toward specific ends, not toward vague ideals. Before the campaign is started, it is wise to determine the status of knowledge of the clientele we wish to reach and the diversity of attitudes which may be held by them. Certain materials should be directed toward fathers and toward adolescent girls.

3. Parents are more interested in an individual appeal about their own baby than in the general status of maternal mortality in their community.

4. Time, thought, and funds are needed if any health education campaign is to succeed and it is the admin-

istrator's responsibility to see that these are provided if he expects results from his campaign.

Presented before the Public Health Section, The First American Congress on Obstetrics and Gynecology, September 15, 1939.



N.P.S. Has Staff Change

FLORENCE ELEANOR SPAULDING will succeed Elizabeth J. Mackenzie as vocational assistant in public health nursing with the Nurse Placement Service in Chicago on June 1. Miss Spaulding has a broad nursing experience including work in rural and urban areas, and in official and voluntary agencies. She was graduated from St. Luke's Hospital School of Nursing, Cleveland, Ohio, in 1924; has had postgraduate work in public health nursing at Western Reserve University in Cleveland; and received her B.S. degree from Teachers College, Columbia University, New York City, with graduate study in health education. She has served with the American Red Cross as a county nurse in Pennsylvania, as supervising nurse in a generalized service in Ohio, and as nursing field representative for Indiana. She has taught home hygiene classes on the Pacific Coast, and served temporarily as home hygiene supervisor of the American National Red Cross in Washington, D.C. She has done industrial nursing in New Jersey, and clinic and visiting nursing in Texas. Since 1938 she has been director of education and school nurse in the Community High School, Pekin, Illinois, where her duties have included vocational counseling to high-school students, and teaching.

Elizabeth J. Mackenzie will go to



Florence Eleanor Spaulding

Virginia as director of the Norfolk City Union of the King's Daughters—which is a visiting nurse association in Norfolk. Miss Mackenzie is perhaps best known through her 13 years as associate director of the Henry Street Visiting Nurse Service in New York City, from 1925 to 1938—during which time she served as acting general director for one year. Previous to 1925 she held various rural and urban positions in the State of Alabama and in Philadelphia, Pennsylvania. She went to the Nurse Placement Service in 1938. (See PUBLIC HEALTH NURSING, August 1938, p. 496.)

Information Please

By LOUISE HOPWOOD

Part I

Interesting data on employees in nonofficial nursing agencies, obtained from the N.O.P.H.N.'s Yearly Review, are presented here

WHO ARE the non-nurse professional employees in public health nursing agencies? What is the usual charge for a full-pay visit? Who does parochial school nursing? How do nursing agencies coordinate their services in the community? These are a few of the questions the National Organization for Public Health Nursing is asked. This article, the third in a series based on the 1938 Yearly Review,* attempts to answer some of these questions for you. Answers to the rest will be published in subsequent issues.

In order to gather the material on which to base these answers, 1051 questionnaires were mailed to all types of agencies in every section of the country, in May 1938. A total of 594 agencies replied to the questionnaire. The non-official agencies, health departments, and boards of education were the only agencies which were asked the questions to be discussed here and in the subsequent three articles in this series. A total of 225 nonofficial agencies, 194 health departments, and 119 boards of education replied in a usable form. The sample is considered only fairly representative so far as size of agencies is concerned as the number of one-nurse organizations in the whole country is more than this sample covers. It was

found that many of the smaller agencies did not answer the specific questions on the Yearly Review schedule.

OTHER PROFESSIONAL EMPLOYEES

The non-nurse professional employees in public health nursing agencies include nutritionists, occupational therapists, physical therapists, mental hygienists, and a group of "others," among whom are doctors, educational supervisors, dentists, and technicians.

Table I shows the number of non-nurse professional employees according to type of profession. More than one half of the full-time employees were nutritionists. It is interesting that more than one third of the part-time workers had other professions than those listed here, for example, social work, health education, and laboratory service.

When this material was analyzed according to size of agency, it was found that part-time workers were more popular with small agencies. Thirty-six of the full-time non-nurse professional employees were engaged by 8 agencies having nursing staffs of 50 or more nurses.

When the salaries of the full-time non-nurse professional employees were studied, it was found that the median monthly salary for the 54 employees was \$153 per month. This salary is approximately the same as that paid to supervisors in nonofficial agencies in 1938. Even though the sample is a small one on which to base median salaries it is definitely shown that mental hygienists receive higher compensation than the other non-nurse professional

*Hopwood, Louise. "Going Forth." *PUBLIC HEALTH NURSING*, November 1939, p. 624.

Hopwood, Louise. "Income in Nonofficial Agencies." *PUBLIC HEALTH NURSING*, January 1940, p. 39.

TABLE I

TYPES OF NON-NURSE PROFESSIONAL WORKERS EMPLOYED IN NONOFFICIAL AGENCIES ACCORDING TO NUMBER OF AGENCIES EMPLOYING SUCH WORKERS AND NUMBER OF WORKERS EMPLOYED

Type of profession	Full time		Part time	
	No. of agencies	No. of employees	No. of agencies	No. of employees
Nutritionist	15	28	8	9
Occupational therapist	4	6	1	1
Physical therapist	5	11	1	1
Mental hygienist	6	6	8	8
Other	2	3	7	12

workers. The salaries of part-time employees were not studied.

CLERICAL EMPLOYEES

Of the 225 nonofficial agencies a total of 160 agencies reported that they had full-time clerical help, 32 agencies had only part-time help, and 33 agencies had no clerical help. Of these 160 agencies, 94 had only one full-time clerical employee and only 21 had 5 or more clerical employees. The amount of clerical help is in proportion to the size of the professional staff. Sixty-five of the 145 agencies employing less than 10 nurses, either depended on part-time help or else had no clerical employees.

The smaller the agency, the less the clerical help. One fourth of the agencies employing 2 to 4 nurses, and 16 of the 26 one-nurse organizations had no clerical employees.

The workers in the 21 organizations employing 5 or more clerks were tabulated according to the type of work performed. The most usual work was described as general clerical work in central or field offices. In the 21 agencies there were 104 such workers. Only 22 stenographers were mentioned. Sixteen agencies reported they had full-time bookkeepers. Secretaries, in addition to the stenographers mentioned above, were employed by 12 agencies,

TABLE II

NUMBER OF AGENCIES EMPLOYING FULL-TIME PAID CLERICAL WORKERS ACCORDING TO NUMBER OF NURSES EMPLOYED

Number of nurses employed	Total agencies	Number of full-time paid clerical workers					Part-time paid clerical workers, but no full-time paid clerical workers	No paid clerical workers
		15-24	10-14	5-9	2-4	1		
Total agencies	225	6	3	12	45	94	32	33
100 nurses and more	6	6	—	—	—	—	—	—
50-99	8	—	2	5	1	—	—	—
25-49	14	—	—	5	8	1	—	—
15-24	25	—	1	1	20	3	—	—
10-14	27	—	—	—	11	16	—	—
5-9	58	—	—	1	4	42	9	2
2-4	61	—	—	—	1	26	19	15
1	26	—	—	—	—	6	4	16

TABLE III
NUMBER OF FULL-TIME NURSES BY NUMBER OF FULL-TIME PAID CLERICAL WORKERS
ACCORDING TO NUMBER OF NURSES EMPLOYED

Number of nurses employed	Number of full-time nurses	Number of full-time paid clerical workers	Number of full-time nurses per full-time paid clerical worker
Total	3172	423	7.5
100 nurses and more	826	104	7.9
50-99	474	54	8.8
25-49	477	57	8.4
15-24	491	53	9.3
Less than 15 nurses	904	155	5.8

and 9 agencies employed registrars and switchboard operators. The other clerical workers were not classified as to duties.

Table III shows the number of full-time nurses per full-time paid clerical worker. The number of full-time nurses includes directors, supervisors, and staff nurses. Only 59 agencies employed part-time workers. Therefore, an estimation of their time was not computed, as it would affect the averages only slightly. The number of clerical workers per nurse was most adequate in the agencies employing 100 nurses and over, as far as the sample is significant. The supply was least adequate in the agencies employing 15 to 24 nurses. The smaller agencies of less than 15 nurses have been grouped together as the average is fallacious because so many of the small agencies employ no full-time clerical workers.

WPA NURSES

Of the 538 nonofficial agencies, local health departments, and boards of education reporting this year, a total of 60 agencies stated that they had 385 Works Progress Administration nurses working under their supervision. Of these 385 nurses, the local health departments were supervising 296 in 36 agencies. The plan of each agency for these nurses was asked. Eighteen agencies did not answer this question in a usable form. Of the remaining 42 agencies, 26 said they had no plans for them and 8 agencies said that they were trying to train them for public health nursing employment or that they would take them on their staff at the completion of the project. The plans of 5 agencies were rather indefinite. In 2 places the project had been discontinued and 1 agency was encouraging the nurses to return to private duty.

COMMENTS

The following comments on these findings are presented by the general director of the National Organization for Public Health Nursing:

It has been rather a surprise to find that nutritionists—28 in all—are employed full time by 15 nursing agencies, and 9 are employed part time by 8 agencies; yet out of 225 nonofficial

agencies, the showing is poor. It is to be hoped that all of these agencies have access to nutritionists for consultant service, even though they do not appear on the pay roll. The whole question of how to use the consultant service of specialists interests the N.O.P.H.N. very much. We would appreciate having reports, studies, or descriptions of success-

ful arrangements for consultant services in the various fields allied to public health nursing.

One of the recommendations frequently made by the N.O.P.H.N. is to increase clerical service in the interest of releasing more of the nurse's time for field work. One full-time clerk in a staff of five or more nurses and part-time service in smaller staffs would seem an economic necessity. Yet this review shows that a quarter of the staffs employing 2 to 4 nurses had no clerks whatsoever. Sixty-five of those with less than 10 nurses depended on part-time clerical help or had no help. It would seem advisable for agencies with staffs of 5 to 15 nurses to try adding a full-time clerical worker, turning over to her all copying, totaling, routine reporting, and office details. It is rather surprising that no agency reported the use of a dictaphone, which family case-work agencies are finding a timesaver. The N.O.P.H.N. has requested informa-

tion on this point in the 1939 yearly review.

It is encouraging to see that only 385 WPA nurses are employed in the agencies in this sampling. There would seem to be two definite lines to take in handling this situation: One is to assist any of the WPA nurses who have the necessary basic qualifications and interest to prepare for staff positions; the other, to assign to them special projects on which they work under supervision pending employment elsewhere. It is obviously desirable that other employment opportunities should be offered WPA nurses and accepted whenever possible.

DOROTHY DEMING, R.N.

*General Director, National Organization
for Public Health Nursing*

This is the first of four short articles on the information secured in the 1938 Yearly Review of the National Organization for Public Health Nursing. Two articles have appeared previously. (See footnote, page 307.)

(Continued)



NURSE PLACEMENT SERVICE



announces the following placements from among appointments made in the various fields of public health nursing. As is our custom, consent to publish these has been secured in each case from both nurse and employer.

- *Elizabeth Hill, Director, Visiting Nurse Association, Los Angeles, Calif.
- Marguerite Wollangk, Nurse-Supervisor, Greyhound Travel Stations, Chicago, Ill.

- *Laura Merck, County Nurse, Marshall-Putnam County, Illinois State Department of Public Health.

Mrs. Ruth Bartle, Community Nurse, Montgomery County Tuberculosis Sanatorium Board, Hillsboro, Ill.

Kathryn Boardman, Staff Nurse, Visiting Nurse Association, Chicago, Ill.

- *Mrs. Isabelle Gabriel, Field Nurse, City Health Department, Chicago, Ill.

*Catherine Austin, Staff Nurse, Visiting Nurse Association, Pittsfield, Mass.

*The N.O.P.H.N. files show that this nurse is a 1940 member.

Demonstration of Teaching Materials

AN EXHIBIT of demonstration teaching materials was prepared by the Louisiana State Department of Health for the nurses attending the annual meeting of the Louisiana State Organization for Public Health Nursing, Shreveport, November 21-22, 1939. The articles used in the demonstration were collected from rural nurses who used the materials in their work. The exhibit was set up as follows:

Table I: Registration book for visitors; paper patterns of garments displayed for distribution to visitors.

Table II: Exhibit of teaching materials for maternal health conferences.

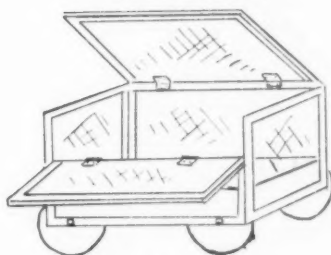
1. Diet for the expectant mother—tray containing plaster replicas of foodstuffs, borrowed from local refrigerator concerns (as illustrated).
2. Setup for perineal care—quart bottle containing cleansing solution and jar containing large cotton balls.
3. Maternity binder.
4. Maternity garments—maternity skirt and smock hung on rack (as illustrated).
5. Newspaper pad for bed.

Table III. Exhibit of teaching materials for child health conference.

1. Crib made of light-weight wood, well



TRAINING RACK
(FOR THREE-YEAR OLD CHILD)



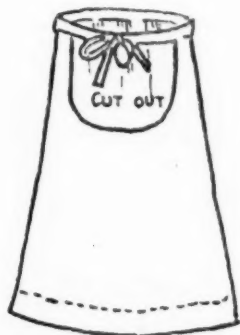
SCREENED CRIB



DIET FOR PREGNANT WOMAN

screened with one-sixth inch mesh screen (as illustrated). Small, hard mattress covered with oilcloth; small newspaper pad covered with unbleached muslin, placed on top of

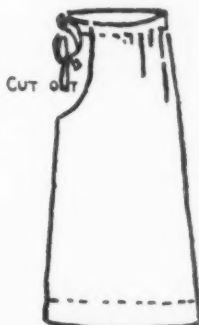
MATERNITY DRESS



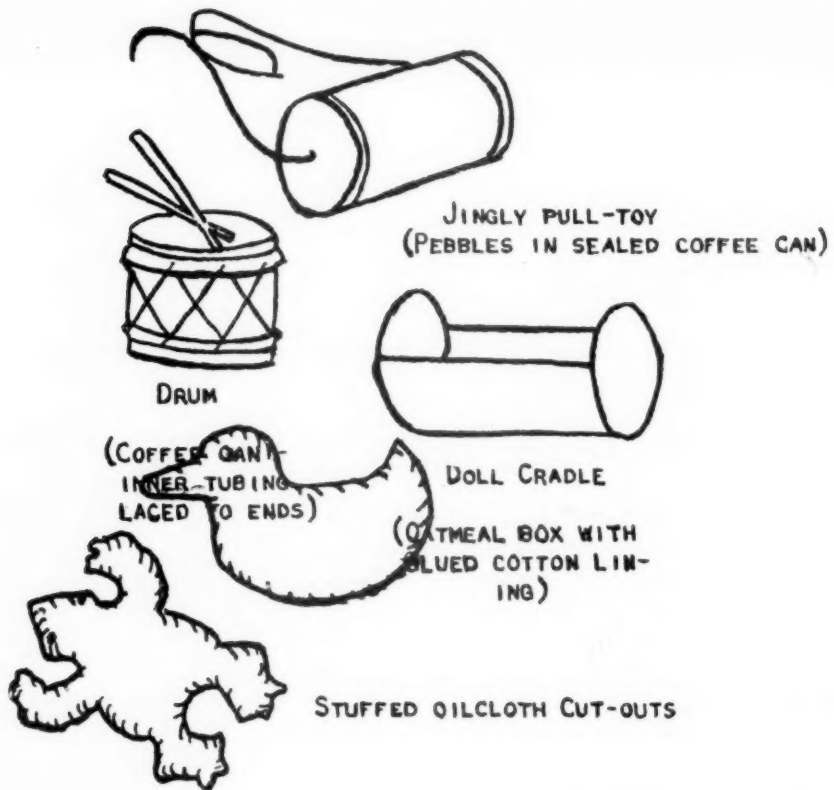
SKIRT
(FRONT VIEW)



SMOCK



SKIRT
(SIDE VIEW)



bottom sheet under baby. Small Negro doll wearing gown opened down back.

2. Bassinet improvised from large laundry basket. Mattress covered with oilcloth. Small newspaper pad covered with diaper, placed on bottom sheet under baby. Small white doll wearing outing flannel drawstring gown for cold weather.

3. Baby tray containing soap dish and soap, jars for nipples, boiled water for baby, olive oil, cotton balls, cotton swabs for mother and boiled water for cleansing nipples, nursing bottle, bar of soap into which safety pins were stuck.

4. Training rack for three-year-old child (on page 311). Board with five nails for wash cloth, tooth brush, tin cup, oilcloth bib, and sun suit.

5. Complete layette.

6. Pureé demonstration materials—jar with strainer and measuring spoon.

7. Homemade toys for infant (as illus-

trated). Oilcloth cutouts, stitched together and stuffed with cotton, representing frogs, alligators, fish, elephants, ducks, and rabbits. Jingly pull toy made of coffee can filled with pebbles and sealed with a cord through either end.

8. Homemade toys for child from one to six. Unpainted wooden blocks. Toy wagon made from cigar box. Small wooden train whittled from single block of wood. Drum (as illustrated) made of one-pound coffee can, on either end of which cuts of inner tubing were stretched, these being laced together over the sides. Small cradle (as illustrated) cut from round oatmeal box.

9. Publications of United States Childrens Bureau.

10. Light-weight tin hand trunk for use as packing case for assembled material.

LOIS GRAY, R.N.

Field Advisory Nurse
Louisiana State Department of Health

Coöperation Is More Than Being Friendly

By KATHLEEN M. LEAHY, R.N.

Effective coöperation between the social worker and the public health nurse in the rural community requires a planned technique of working together

COÖPERATION is defined in the dictionary as "joint effort". Someone once defined coöperation as "being able to work with another without fighting about it." In the very nature of things, the work of the social worker and the public health nurse is a joint effort, but whether this effort is oiled by the *spirit* of coöperation depends on the vision, the ideals of service, and the ability to put first things first, on the part of both. If the two groups are going to coöperate, they must have a definite goal in mind—one which is reasonably attainable. And equal responsibility must be accepted by both groups for the project.

The spirit of coöperation, understanding, and appreciation between the social worker and the public health nurse in the rural sections is more the rule than otherwise. But because of the increasing number of workers in these two professional groups, problems of relationships are constantly arising that need thoughtful consideration.

The principles of coöperation are the same, whether applied in an urban or rural area. But sometimes it takes more imagination and effort to put them into effect in rural areas where each profession may be represented by just one worker, because personalities do enter in. Under urban conditions, routes of coöperation are usually through the agency, and the individual workers may have little to do with each other on a personal basis. In rural areas, however, coöperation must be carried on face to face.

The basis for coöperation is understanding and respect for the other person—respect for her personality, her preparation, her professional ability, and her desire for professional growth and development.

Perhaps the public health nurse and the social worker should each pause occasionally and ask herself, "Can I command respect from the personnel of the other professions?" Each may well consider whether she is making an effort to meet the increasingly higher standards of her professional group, by her attendance at conferences and institutes, by further university study, and by a continuous program of professional reading. This responsibility falls on each one of us.

It is essential that the social worker and the nurse should know each other, not only personally but through close professional contact, in order to understand each other's problems—such as case-load, transportation difficulties, or lack of social and medical resources. Frequent informal conferences will give a comprehension of the scope, responsibilities, and difficulties of each other's work. For instance, sometimes it is possible when one worker is going to a distant part of the county to leave a message for the other worker or do a small errand, thus preventing duplication of effort and saving mileage and time that might be used to advantage elsewhere. At the same time, planned interagency staff conferences should be worked out at stated intervals. These are a valuable aid in increasing understanding and pro-

viding for a discussion of the medical and social problems and needs of families carried jointly.

In rural areas, staff supervision is not as easily available to either the social worker or the public health nurse as in urban organizations, and each must make her own decisions in a great many situations, without professional advice. There should be an appreciation of this fact before criticism is made regarding the work of the other.

TECHNIQUE OF REPORTING BACK

Professional courtesy should be maintained at all times, and it will produce dividends in coöperation. Let us take, for example, the technique of reporting back. There is general agreement that a case belongs primarily to the agency that first cared for it. Therefore, the agency which seeks the professional assistance of another agency is entitled to the courtesy of being informed what the second agency does, and of being considered in the making of further plans. This reporting back takes time; but it is so effective in securing coöperation that it is well worth time and effort. A routine method for reporting back to the source should be established.

SHARING PROFESSIONAL VISITORS

When an outstanding leader in either professional group is in an area, it is a courtesy to share her generously with workers in the other group so that they may gain from her wider experience and vision. Recently when a leader in public health nursing visited a very rural county, the nurse made it possible for the social worker to participate in the conferences as well as to attend the dinner given for the guest. Later the social worker said that the opportunity had been invaluable to her and that she had gained a deeper insight into the aims of public health nursing.

Ways in which the social worker and the public health nurse may work to-

gether for their common goal—the welfare of the individual and the family—are illustrated in the following case:

Mrs. Smith, a patient with moderately advanced tuberculosis, was referred to the public health nurse for supervision. The patient, with her husband and 16-year-old son, lived with her sister's family in a remote part of the county. For financial reasons it was necessary that she be cared for in the home. In making a plan for bedside care, the public health nurse uncovered so many other problems that she referred the family to the social worker for joint assistance in returning the patient to health and in protecting the others in the family.

It was found that the family income was insufficient since Mr. Smith had only part-time employment. Two little daughters, badly in need of dental care, were staying with the grandparents, who already had a totally inadequate income. The 16-year-old son was attempting to help his aunt in the care of his mother. He was a sensitive, artistic lad who suffered keenly from the psychological, social, and economic problems which the family faced. Together the public health nurse and the social worker carried through a plan in which the boy was released from the nursing responsibility for his mother; part-time work found for him; and arrangements were made for his return to school. Adequate nursing care by a competent neighbor under the nurse's supervision was arranged.

The father, relieved of worry over his wife's illness, secured a full-time job and was able to contribute to the support of the two little girls. Old-age assistance was arranged for the grandparents. Dental care was secured for the two children. With economic pressure removed, psychological differences and friction within the family decreased.

Later the social worker planned a financial arrangement with relatives so that it was possible to send the mother to the sanatorium. Now the family, under the objective supervision of the public health nurse and the social worker, is no longer a health menace, and is making a happy adjustment in their community. All of this took months to accomplish, and its ultimate success depended on careful planning, and frequent discussions, and on the willingness of both social worker and the public health nurse to be open-minded in regard to each other's aims and points of view.

Years ago, Mary E. Richmond suggested a workable plan for coöperation with other community groups. This

plan, if followed, could be very effective in our present social program: "Study and develop your work at its point of intersection with the other services and social activities of your community. Learn to do your daily tasks not any less thoroughly, but to do them from the basis of the whole and with that background always in mind. After all, society is one fabric, and when you know the resources of your community, both public and private, and the main trends

of its life rather than any particular small section of it, you are able to knit into the pattern of that fabric the threads of your own specialty. There are eddies and flurries, not to say crazes. Disregard them and let your minds carry through to the practical next steps by which genuine social advance is achieved."*

*Through the Ages. Published by Family Welfare Association of America, 122 East 22 Street, New York, p. 46.

A Board and Staff Study Health Insurance

By MARGARET BRACKENRIDGE HALE

SINCE health insurance in all its phases has attracted such widespread interest both nationally and locally, the Nursing Committee of the Pasadena Visiting Nurse Association decided that the Board of Directors and the staff should be conversant with its history and latest developments. A committee was appointed to make plans for a study on health insurance, which was to include the place of nursing in a health insurance program.

The study guide¹ prepared jointly by the American Nurses' Association and the National Organization for Public Health Nursing was the spark that kindled the enthusiasm of the Nursing Committee and was invaluable in building our program.

With the crusading spirit of the lay sister we wished to embark on a long course of study to learn everything about health insurance. But our director, being wise in the ways of board members, convinced us that we could cover considerable ground in two meetings, without lagging of interest.

Our many years of experience in being

board members have left us with several definite ideas concerning our species:

1. Board members do not march willingly to the fountain of learning. The only nearly infallible method of assuring their attendance at an educational meeting is to give them a job to perform.
2. A job which involves real study stimulates the board members' interest infinitely more than listening to speeches.

Guided by these principles, the committee divided the subject into its various phases and gave an assignment with suggested bibliography to each participant, requesting that she study the chosen books and periodicals and prepare a paper on her subject.

Since we wished to keep the gathering small enough to allow free discussion, invitations were limited to the Visiting Nurse Association Board of Directors, staff, volunteers, and Nursing Committee. The city health officer, who is chairman of our Medical Advisory Board, was interested in the project, and he not only took part in both meetings but assisted in preparing the bibliography.

The participants in the discussions

included six board members, one member of the staff, the director of nursing of the City Health Department who is a member of our Nursing Committee, and the health officer. The program included the following subjects:

First meeting

A brief outline of the need for more adequate medical care, using the Report of the Committee on the Costs of Medical Care² and subsequent studies as background—board member.

Argument for socialized medicine—board member.

Platform of the American Medical Association on health insurance—board member.

General discussion of prepayment plans for medical care—board member.

Existing American prepayment plans, with special emphasis on Ross-Loos clinic in Los Angeles—board member who has used Ross-Loos service over a period of years.

Impartial discussion of attitudes of American Public Health Association and American Medical Association toward health insurance—health officer.

Second meeting

Health insurance in other countries—board member.

Hospital insurance—staff nurse.

Nursing insurance—director of nursing of City Health Department.

California Physicians' Service—board member.

The meetings were thrown open for informal discussion. The questions which were asked provoked interesting answers and comments, and we believe the study proved its worth, because of the interested and well informed coöperation of each member of the group.

It was thought that the place nursing would take in the insurance program would probably be in connection with the home nursing follow-up in a hospital insurance plan or as a part of a plan for medical care. The consensus was that private agencies would be the leaders in the experiment of a health insurance plan.

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An Experiment in Exchanging Nurses

A PLAN of exchanging nurses with other agencies was initiated by the Henry Street Visiting Nurse Service in September 1939. This experiment was based on the following needs:

An agency with a heavy graduate teaching program needs to retain its able nurses for effective family health service, for student guidance, and for supervision. At the same time the agency and the nurses themselves see the value of a broadened staff experience through work in other types of organizations. Especially is this true if the agency is to give experience to graduate students who will be employed subsequently in many different kinds of situations. There is danger that if the staff nurse resigns to secure this added experience she will not return to the agency.

The Nursing Committee is sympathetic toward this problem and favors the idea of experimentation to overcome the hurdle through an exchange of nurses with other types of agencies, especially official or rural ones. It was easy to find agencies willing to take advantage of such an arrangement, since rural organizations are eager to find opportunities for outstanding nurses to have a block of work under close supervision, often as a preliminary to assistant supervision in their service.

Stipulations regarding this exchange were arranged by the two agencies as follows:

As an eligibility requirement the nurse must have at least two years of outstanding staff work and a year's postgraduate study in public health nursing. She must be able to drive, and in some instances ownership of a car is required.

Selection is made on the basis of the performance and potentialities of the nurse.

The period of time is stipulated as one year.

Each nurse remains on her original pay roll and receives her regular salary while working

in the exchange agency, except that supervisors would receive the maximum staff salary.

The nurse pays her own transportation to the exchange center, but transportation on duty is paid by the organization served, according to its regular policy.

Each nurse will have the advantage of the regular introductory and staff education program of the organization.

Monthly reports are sent by the nurse to her own organization. Each organization reports to the exchange organization on the work of the exchange nurse every six months.

A nurse receiving this privilege accepts responsibility for returning to her own organization for a reasonable period of time.

Two exchanges have been arranged so far. One nurse from the Henry Street Visiting Nurse Service has exchanged with one from the Colorado State Division of Public Health, and another with a nurse from the Missouri State Board of Health. Although only seven months have elapsed since the exchange was started, a progress report is made here in order to give others some idea of the results to date.

The three agencies consider that the adjustment of these nurses to their new field has been most satisfactory. Earnestness has characterized the work of each. The usual slowing up of the work at the beginning of any new appointment was lessened somewhat by the careful choice of exchange nurses and their maturity. They have been well accepted by their co-workers and have contributed to the breadth of understanding of health work in the places where they are working. Comments from the state directors of nursing and from the nurses themselves are quoted here.

Ruth E. Phillips, director, Division of Public Health Nursing, Colorado State Division of Public Health: Because the arrangement existing between us has been a very pleasant and profitable one insofar as we are concerned, we are writing to have your comments concerning a repetition of the plan during the coming year.

Helena A. Dunham, director, Division of Public Health Nursing, Missouri State Board of Health: The exchange plan has been successful from our point of view. The program of the agency has not been interrupted or hindered in any way. It will assist the nurse in broadening her experience, which will show results when she returns to her own staff.

The nurses themselves express their opinions:

Charlotte Sanderson, Henry Street nurse assigned to Missouri: My experiences have been so varied and so rich that they give me a broader view of public health throughout the country today. I feel that I have become much better equipped to face courageously difficulties in this field.

Margaret Ranck, Missouri nurse assigned to Henry Street Service: The opportunity to participate in a staff education program somewhat different from that in my own state is good for me. Having clearly defined policies to cover so many possibilities that might occur in a nursing day will send me back to a rural area more alert to help my committee think through their community problems and develop these policies. Lightening the nurse's load by sharing it with the committee—and through them the county—may enable them to work out a plan for rearranging her time so that more can be spent in demonstration bedside nursing. Perhaps their efforts in working out these details might lead them to see the advantages of employing another nurse.

The record work on a daily basis has been good discipline for a rural nurse who because of the push of more apparently urgent work sometimes neglected to complete each day's record work the day the work was done. One felt that there might be a calmer day around the corner. Of course as a rule the day never came.

I believe I have gained among many things, tolerance, a spirit of coöperative endeavor, an ability to give responsibility to others for a problem that is not peculiarly my own, and some knowledge of the tact and bolstering of ego necessary in teaching patients, undergraduates, and other nurses.

Florence Burnett, Henry Street nurse assigned to Colorado: Geography books do not

give one a true picture of this beautiful country of ours, and only by staying here awhile can its true beauty be realized. In the city, rain is many times considered a nuisance, an inconvenience. Here it means life, food—a necessity. Soil isn't just something that turns to mud when rained on. It really is the backbone of the nation.

These vast areas of land house and feed many hundreds of people. Transportation is lacking in many places. This not only becomes a problem socially, but a health problem. Visits to physicians can be made only as the last resort. Prevention is a new word here and we must sell ourselves and our product as we would sell cattle, horses, or pigs. These people must know it is good before they will buy. That in itself is a challenge to a nurse who has been used to having people already "sold." We have to make them see the advantages of having their cows tested for tuberculosis, having their drinking water made safe, or changing the sites of their outdoor toilets. Nobody ever worried over them before—why all this fuss now?

The exchange service has done much for me. It has shown me how others live, but more than that, it has taught me how to live. Sincere simplicities of life *are* life and they are yours for the asking, taking, and giving—which we in a city, tense and too well accommodated, often fail to see.

Many questions are still to be answered when the exchange nurses return to their home agencies. Then we shall want to summarize the year's work of each exchange nurse and compare it with that of the home nurse in the previous year. We shall want to compare the type of field work and student guidance of the returning nurse with the work she did previously. Only after a longer period of time will an evaluation of the experiment be possible, but in the meantime it seems exceedingly worth while from the standpoint of both the agencies and the nurses.

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A Study of College Nursing Services

By FERN A. GOULDING, R.N.

A survey of college nursing services in five north central states, by the Subcommittee on College Nursing Services of the N.O.P.H.N. School Nursing Section

COLLEGE nursing service is one of the newer branches of the nursing profession. It is so new that as yet there is no clear definition of the nurse's duties or the type of preparation most beneficial to the service, no uniformity of salary scale, and no professional organization prepared to give the nurse special guidance in the performance of her duties.

The college nurse is a pioneer, and many problems beset her, especially when she must carry major responsibility for the health service of the college as frequently occurs in smaller educational institutions. By common campus consent, a great variety of duties and responsibilities are directed to the nurse's office, especially when she is the only person employed in the college health service. Frequently doubts arise in her mind as to the proper ethical procedure in the handling of health situations. No nurse wishes to assume responsibilities for the diagnosis and treatment of disease; yet these duties are frequently expected of her in colleges where there is no full-time physician in the college service, or where the part-time college physician fails to give adequate instructions to be carried out by the nurse in case of emergencies. There is apparent need for clarification of the college nurse's duties so that there will be less misunderstanding, and greater assurance of adequate and safe health service for all students.

At the 1938 meeting of the North Central Section of the American Student

Health Association, a group of fifteen nurses met for an informal discussion of college nurses' problems. The North Central Section includes five states—Iowa, Minnesota, Wisconsin, and North and South Dakota. It was decided by the group of college nurses at this meeting that a survey should be conducted during the ensuing year to learn as much as possible about the duties of other college nurses in the section. The coöperation of the National Organization for Public Health Nursing was solicited in the management of the proposed survey. The N.O.P.H.N. appointed a Subcommittee on College Nursing Services of its School Nursing Section, to undertake the study. The members are as follows:

Fern A. Goulding, Iowa State College, Ames, Iowa, *Chairman*

Jane Foster, Smith College, Northampton, Massachusetts

Raidie Poole, State Teachers College, Superior, Wisconsin

Catherine Vavra, State Teachers College, Duluth, Minnesota

During the winter 1938-1939, a survey was made of college nursing services in the North Central Section. The results of this study, which were read at the annual meeting of the section held at River Falls, Wisconsin, in May 1939, are presented here.

During February 1939, questionnaires were sent to 89 of the 99* colleges in the North Central Section. Sixty-seven questionnaires, or 75 percent, were re-

*Exclusive of two private normal schools.

turned with sufficient data to be included in the study. These replies were from 9 universities and colleges under public control, 22 teachers' colleges, and 36 privately controlled colleges. (See Table I.)

Because of the wide difference in type of nursing service required in the many colleges represented, the data are tabulated under three divisions according to the type of college. Nurses in each division perform somewhat the same kind of service. There is a marked difference in the type of service performed by a nurse working alone who is largely responsible for the health program of a smaller college and that of one of a group of nurses under direct medical supervision in the larger university health center.

COLLEGES EMPLOYING NURSES

Table I shows that 55, or 82 percent, of the reporting colleges employed full-time nurses to aid with the physical care of students. Only one of the publicly controlled universities did not employ a nurse; medical care in this school was given entirely by physicians. In three of these institutions, well staffed hospitals were maintained, and nurses were under the direction of full-time physicians. Of the 22 reporting teacher-training institutions, 19 employed nurses, and of these 3 employed more than one nurse. Of the 36 replies from private colleges, 9 colleges each reported the employment of 2 nurses, and 19 colleges each employed 1 nurse. Twelve of these private colleges employed part-time nurses only. Eight colleges had no nursing service.

One hundred and sixteen nurses were employed in the 55 reporting colleges. Eighty-eight nurses were giving full-time service, and 28 were engaged in part-time duty, combining in most instances their nursing service with an academic study program.

The academic and professional prep-

aration of these nurses is summarized in Table II. It is significant that 25 nurses, or only 21.5 percent of the entire group, had special preparation or experience in public health activities.

TITLES AND FACULTY RANK

A wide variety of titles were given to the college nurses, such as chief nurse, supervisor, general-duty nurse, clinic nurse, college nurse, instructor, instructor in health education, health supervisor, and assistant dean of women. Only in a few instances did the nurse's title suggest the broader scope of her duties.

Although it is believed that in certain instances the inquiry concerning the matter of faculty ranking was misunderstood, 23 nurses, or 19.8 percent, stated that they were given faculty rank. Sixty, or 51.7 percent of the nurses, stated that they did not have such ranking, and 33, or 28.5 percent, did not reply to the question.

NURSES' DUTIES

Nurses' duties varied considerably in the several institutions coöperating in the study. One hundred and eight nurses reported data concerning their specific duties. Forty-three nurses, or 39.8 percent of this group, included a health-promotion program as part of their service. The replies do not indicate whether these nurses carried a formal, planned health-education program or merely a casual one incidental to their care of sick students.

Another group of 43 nurses reported their only duty as that of care of the sick, either in hospitals, infirmaries, or students' rooms.

Although doubtless several nurses, especially those employed in the smaller institutions, make calls upon sick students and give bedside care in the students' rooms, only 3 nurses in 3 institutions spoke of this duty specifically.

Fifteen nurses, 13.8 percent of the reporting group, carried classroom

TABLE I
EMPLOYMENT OF NURSES IN INSTITUTIONS OF HIGHER EDUCATION OF THE NORTH
CENTRAL SECTION, BY TYPE OF COLLEGE

	Total institutions concerned	Institutions by type		
		Univ. and prof. sch. pub. controlled	Teacher tr. sch. pub. controlled	Univ. and colleges priv. controlled
Institutions reporting the employment of full-time nurses	55	8	19	28
Employing more than one nurse	15	3	3	9
Employing one nurse only	40	5	16	19
Institutions reporting the employment of part-time nurse only	12	—	—	12
Institutions reporting that no nurses are employed	12	1	3	8
Total institutions in North Central Section	99 ^a	9	26	64
Questionnaires sent	89	9	26	54 ^b
Questionnaires returned	67	9	22	36

^a Exclusive of two private normal schools.

^b Ten private professional schools were omitted from the study.

TABLE II
PROFESSIONAL AND ACADEMIC PREPARATION OF NURSES EMPLOYED IN COLLEGES OF
NORTH CENTRAL SECTION, BY TYPE OF INSTITUTION

	Total nurses employed	By type of institution		
		Univ. and prof. sch. pub. controlled	Teacher tr. sch. pub. controlled	Univ. and colleges priv. controlled
Total nurses employed	116	55	24	37
Full-time	88	47	21	20
Part-time	28	8	3	17
Registered nurses	111	55	24	32
Without professional registration	5	—	—	5
With college degrees (A.B. or B.S.)	14	5	6	3
With 1 to 3 years of college but no degree	34	10	9	15
With graduate study	4	—	3	1
With public health nursing certificate	16	3	10	3
With public health experience but no certificate	9	1	4	4
With academic training in health education	25	6	11	8
With teaching experience	8	2	6	0

TABLE III
SALARIES PAID TO FULL-TIME COLLEGE NURSES OF NORTH CENTRAL SECTION

	Nurses receiving salary and maintenance	Nurses receiving salary but no maintenance
Number of nurses	28	9
Salary range	\$450-\$1875	\$675-\$2400
Average salary	\$ 999	\$1517
Median salary	\$1000	\$1600
Salaries of nurses carrying educational programs in addition to nursing duties		
Number of nurses	7	5
Salary range	\$1000-\$1875	\$1275-\$2000
Average salary	\$1287	\$1686
Median salary	\$1100	\$1760
Salaries of nurses not carrying educational programs		
Number of nurses	21	4
Salary range	\$450-\$1500	a
Average salary	\$904	a
Median salary	\$900	a

a Not available.

teaching programs in addition to their care of the sick and health promotion. Only 4 nurses carried an educational program without duties of care of the sick.

Two nurses included certain administrative duties in addition to their nursing service—one acting as dean of women and another as assistant to the dean of women. Another nurse was employed as an admittance officer in the health service of a university, but she had no nursing duties.

Those nurses who combined a teaching program with nursing activities taught from one to five hours a week, to from one to four classes each term. In the majority of cases the classes were required of at least certain groups of students, the range of students in attendance being from 8 to 125. These nurses were responsible for the teaching of the following subjects: personal hygiene, community hygiene, health education, diagnosis, anatomy, first aid, home nursing, school and community health, and physiology. Four nurses taught subjects not directly concerned with the health field—chemistry, biology, and French.

SALARIES

The study of salaries received by college nurses was very involved because of the many differences by which salaries were computed in various institutions. The findings are summarized in Table III.

Certain nurses received full maintenance in addition to monetary remuneration, while others received a salary without maintenance. Some nurses were paid for nine months only, others for ten, and still others on a twelve-months basis. In this study salaries were considered on a ten-months basis.

Because of the uncertainty concerning the matter of maintenance, fourteen salaries had to be omitted from the summary. These salaries ranged from \$500 to \$2000 annually, with an average salary of \$1016 and a median salary between \$900 and \$1000.

A study of remuneration given to 15 part-time nurses showed that it ranged from maintenance or tuition only, or maintenance and tuition, to \$500 and maintenance. Each college had a different manner of handling the compensation for this type of service.

Although data at hand are inadequate for positive statements there was quite definitely a trend for higher salaries among those nurses who carried teaching programs in conjunction with their regular college nursing services. A high percentage of these nurses had their college degrees and in some instances advanced academic study in addition to their nursing preparation.

It is interesting, although possibly misleading because of insufficient data, to compare college nurses' salaries with those of other college personnel. Individual salaries to a great extent depend upon the type of service to be done, the preparation and experience of the person employed, and the budget allowance of the college; therefore, salaries are never exactly comparable.

It is of interest to note, however, that the median salary—\$1600 with no maintenance consideration—of those nurses engaged in college health education compares favorably with the median salary of \$1585 of instructors in state colleges.* Some of the higher nurses' salaries compare favorably with those of assistant professors of state colleges, the mean of which is listed as \$1869 a year.** If the salaries of these nurses who received maintenance in addition to monetary compensation were weighted with \$400, which is the lowest cost of maintenance for ten months, the comparisons would show a lower salary for the nurse. By this weighting of figures the nurses' median salary for those carrying educational programs would then be \$1500. The instructors' median salary is \$1585.

There is considerable variation in the salaries paid to school nurses of various communities. The median staff nurse salary in the sample studied by the National Organization for Public Health Nursing in 1938 is \$1677 for the school

year.* Many public school nurses receive considerably higher salaries than do the college nurses of the North Central Section of the A.S.H.A.

If the average salary of \$999 as shown in the study of the 28 college nurses who received maintenance were weighted with \$400 covering the cost of maintenance, the average salary would only be \$1399, which falls considerably below the salaries paid for the other two types of service—school nursing and college teaching.

MEDICAL SUPERVISION

Only 10 colleges, or 15.4 percent of the 65 reporting institutions, employed both full-time doctors and nurses. Thirty-four colleges, or 52.3 percent, employed nurses and part-time physicians. This part-time service was variable, from regular daily, weekly, or bi-weekly visits by a physician, to a telephone call when a problem disturbed the nurse.

Eleven schools, or 17 percent, depended either upon medical advice or supervision from a medical committee off the campus, or upon supervision of private physicians when called upon by students during illnesses. In 2 schools, nurses were employed, but no physician or other medical supervision was provided for. Five schools had no medical service whatsoever, and 3 schools employed part-time physicians but no nurses.

It appeared from a study of data that college nurses were largely responsible for the administration and efficiency of health services in 47, or 72.3 percent, of the reporting colleges of the section. Although in the majority of the institutions part-time physicians were available for advice, and supervision if necessary, doubtless the actual planning and administration of these campus health programs were directed by nurses.

If the foregoing interpretations are

*Greenleaf, W. J. College Salaries, 1936. Bulletin No. 9, U. S. Office of Education, Washington, D.C., 1937.

***Ibid.*

*Hopwood, Louise. "Going Forth." PUBLIC HEALTH NURSING, November 1939, p. 631.

correct, college nurses were carrying serious responsibilities for the student health services of a majority of the private colleges and teacher-training institutions of the North Central Section.

CONCLUSIONS

The following conclusions are offered by the writer after a study of questionnaires submitted in the survey, informal discussions with many college nurses, and convictions born through 16 years of administrative and teaching service in both a small and a large college.

Need for standard-setting

Because college nursing is new, there is great need for some central source of advice and guidance for nurses now employed in college health services and for those contemplating such employment.

Preparation of the college nurse

The nurse who is wholly or largely responsible for the health service of a college should have advanced academic and professional preparation in addition to her nursing education in order to assume her place in the educational and administrative program of the college.

No special preparation beyond a good basic professional training has been required for the nurse engaged only in care of the sick in a college infirmary. However, the majority of student illnesses are acute, with rapid recovery, and opportunities for health education are great if recognized by infirmary nurses who are trained and interested in disease prevention as well as in remedial treatment.

During the past few years emphasis has been placed upon college training for the nurse who is preparing for administrative or educational positions. College nursing is a type of service where a college degree is a decided asset, particularly if that position carries with it administrative duties, classroom teaching, and health education for the student group. A college degree gives a

better rapport and understanding between the nurse and the administration, the teaching faculty, and the students.

It seems unfortunate that so few college nurses have had public health training, for every college campus is a challenge to a person with a public health consciousness. Opportunities for health teaching on a college campus are practically unlimited. In the health service of a small college, with limited infirmary equipment, the home-visiting program of the nurse is a vitally important phase of her program. It is suggested that public health nurses' training in the technique of making a home visit would afford a splendid preparation for the college nurse who is expected to give nursing service in students' rooms.

It seems obvious that a certain type of postgraduate professional preparation would be of extreme value to the nurse preparing for college nursing service. This is an attractive and interesting phase of nursing which nurses are to be encouraged to enter. They should not be obliged to lose time through lack of knowledge of their specific duties, but should take up their duties with confidence born of adequate preparation. Courses should be given in some of the universities, perhaps as a part of the curriculum in public health nursing, to those nurses who definitely wish to enter this type of service.

Interpretation of qualifications to college administrators

College administrators should be advised of the type of preparation to be expected of the nurses they employ for the particular service they require. In an effort to economize, administrators occasionally employ young, inexperienced nurses who are willing to work for a lower salary during a trial period. This practice is manifestly unfair to the young nurse and definitely militates against efficient management of a health service. The average nurse, only a few

months out of the nursing school and without additional academic or professional training, has little vision or knowledge of the broad scope of both remedial and preventive health work required on the average campus. She soon finds herself in a job much too big for her, becomes worried and dissatisfied, and often seeks a different position in a year or so. The nursing service must then be reorganized by the new nurse.

College administrators should employ nurses who are adequately trained for educational service in addition to their nursing education.

Scope of the nurse's duties

The college administration should understand the limits of a nurse's duties from the professional and ethical viewpoint and should not expect or permit her to overstep them.

Too often a competent nurse is expected to carry a medical advisory, diagnosis, and treatment program during a physician's absence. Duties such as these are a violation of the ethical training of the nurse, and they should neither be encouraged nor tolerated. Nurses in colleges, as in all other branches of the profession, should have dependable medical supervision for all strictly medical service, and for this the college is responsible. Such supervision assures the students of adequate, safe medical treatment. There should be a definition of the nurse's duties, with physician's standing orders for the care of the sick and clinical treatment. The nurse is not a physician, and she should not be expected to assume these responsibilities.

The nurse should not be expected to carry an unreasonable burden of care of the sick, to the detriment of her health and professional morale. A serious problem in many college nursing services is that of the long hours of infirmary duty required during periods of student illnesses. Often for weeks one nurse alone will care for several bed patients,

giving 24-hour service with no professional relief. This practice leads to fatigue and dissatisfaction.

Data concerning nurses' duties showed that many college nurses were filling important campus positions. In many instances, the diversity and multiplicity of their duties were somewhat startling. This was especially true of a nurse who worked alone in one of the smaller colleges. Not only did she care for the sick and have general control of campus welfare, such as housing inspection, food control, and other disease-preventive procedures, but she was available to students for health conferences. These conferences, although time-consuming, are an invaluable part of a college nurse's services, particularly in those situations where medical service is not readily available.

The nurse who is chosen after careful consideration of her educational and personal qualifications should then be allowed freedom and an adequate budget to execute the health program after group planning with an appointed campus health committee. Often the well prepared nurse could give a greater service if provision were made for it in the curriculum and budget. In order to allow time and money for her program the administration and faculty must be made to realize its importance.

A serious handicap to a competent nurse's program is that her time is so occupied with the many details of clinic service or care of the sick that she has no time or strength for the broader health-promotion program. Her program is thus restricted in its scope. It is sometimes limited entirely to remedial care, and disease prevention and health promotion are neglected or relegated to a minor role. Several factors have contributed to this restriction of nurses' duties.

The nursing profession has failed to teach college administrators and other professional people the broader aspects

of the nursing, health-education, and public-health programs. The busy administrator wishes his students given competent care when ill; but in many institutions, with proper adjustments in the budget and curriculum and with adequately prepared and sufficient personnel, a wider, more far reaching disease-prevention program could be maintained. Emphasis should be placed upon an adequate *number* of personnel. It should be obvious to the financial acumen of the college administrator that considerable waste occurs when a highly trained person must restrict her service to the care of the few persons, when with slightly more expenditure for needed assistance she could contribute to the welfare of the greater number.

Moreover, nurses and physicians themselves need to be oriented to this newer phase of their profession. Many members of the profession who do not have the advantages of public health training fail to see the possibilities of health education in a college curriculum. Unless there is a high degree of sympathy with all phases of the health-education and disease-prevention program by all members of the medical and nursing staff, the program will lose much of its value.

In many larger institutions, where the number of sick students demands such an arrangement, nurses are engaged exclusively for care of the sick and health education is carried by a special department. In smaller institutions, however, arrangements may be made advantageously for the inclusion of a certain amount of health education in the nurse's program, if she has the training for such a program. In this case the nurse must be provided with sufficient assistance to care for the sick so that opportunity is allowed for preparation and execution of the educational program. If a nurse is too busy and fatigued from long hours of day and night infirmary duty, she cannot adequately carry educational activities. The nurse should also be provided with

sufficient clerical help. A high-salaried nurse-educator should not be required to spend long hours at routine clerical work while her health-promotion activities suffer.

Another valuable aspect of a nurse's educational program is the contribution it makes to her own education and satisfaction with her job. The constant recurrence of the same type of illness, and the remedial treatments such as are found in the usual college clinic or infirmary—important as they are—are time-consuming and fatiguing and are apt to become monotonous to nurses who need the professional stimulation of a more diversified program. If the nurse does not have broad interests and professional contacts her personal education is sometimes neglected and her professional program often suffers.

Classroom teaching

It is the opinion of the writer that a certain amount of teaching in conjunction with the nurse's regular health service is an important part of a campus-wide health program, if the nurse is academically prepared to teach. Health education is an essential part of a student's education and it is distinctly beneficial to associate this phase of his education with other academic subjects. Too often health education and health service are isolated from the rest of the student's college experience. When the college health department carries an educational program it becomes a teaching department, meeting the student in the classroom as well as in the clinic, and thus becoming integrated into the academic program of the college.

Furthermore, these duties definitely place the nurse on the academic staff, and such a status is beneficial in many ways to both the nurse and her office. The nurse by virtue of her professional preparation has much to give students and when that is supplemented by adequate academic training she should

share in the instruction and leadership of those students.

The nurse's title

A nurse who is academically and professionally qualified to carry the administrative responsibilities of a college health service should have a title that will indicate to students and college personnel the nature of her service and the importance of her position. It is advantageous to the nurse who carries administrative and educational duties that she be given a faculty or administrative rank. With faculty rank and a commensurate salary with periodic salary increases, two things are accomplished.

1. The position that the teaching or administrative nurse holds is given academic dignity and an authority which it may otherwise lack.

2. A descriptive title contributes to a better understanding of the specific duties of any administrative officer. If the nurse is a college nurse by virtue of her specific duties, that is the title she should have. If her duties include academic or administrative service, her title should indicate it.

The title *college nurse* seems adequate for certain types of service, but inadequate for the nurse who is responsible for a broad campus-wide health program, often including classroom teaching. Perhaps the term *advisor in health education* or other descriptive or academic titles might be used in many cases where the term college nurse does not create the proper understanding of the duties of her position.

Remuneration

With the exception of some of those nurses in the teaching group and a few others in the higher salary brackets, many college nurses were distinctly underpaid for the amount of professional training and experience their position required, especially when one considers that these salaries were usually paid on

a nine or ten months' basis, leaving at least two months of idle time each year.

A two or three months' vacation period is very pleasant when the preceding nine months' salary has been sufficient to allow savings which will carry over the three months' idle time. If the salary has been inadequate to allow for this saving, the nurse must annually try to find a summer job to help finance the three months' idle time. This situation makes the college nurse's job less attractive to many who are well qualified to carry on a splendid college health program.

Such below median salaries as many nurses received did not allow for professional and cultural advancement, recreation, personal necessities, insurance and savings, summer idleness, illness, or age. An inadequate income tends to create dissatisfaction and inefficiency in a service program.

If a nurse has been carefully selected for the type of service the college needs, if she has adequate professional and academic training to maintain the same academic status as other college personnel, and if she proves capable of performing efficient service, she should receive a remuneration that is commensurate with her professional and academic training and experience and her efficiency in the management of her service.

SUMMARY OF APPARENT NEEDS

From the foregoing study and discussion, the subcommittee on College Nursing Services offers the following summary of apparent needs of college nursing services:

1. There is a definite need of a national organization or division of an already existing organization to act in an advisory capacity for the clarification of college nurses' duties, their academic and professional preparation, and their salary scale. This organization should act also in an advisory capacity

to college administrators in the selection of college nurses.

2. College nurses need an adequate academic background to permit participation in academic and administrative service.

3. The college nurse's service would be improved by public health training in addition to her basic nursing education. Such additional training would give her a broader vision of modern preventive techniques and working plans for their administration.

4. Specific courses should be developed in university programs of study in public health nursing, where nurses may adequately prepare themselves for college nursing services.

5. College nurses need closer medical advisory and supervisory service, thus avoiding the nurses' obligation to assume medical diagnosis and treatment service.

6. College nurses need adequate nurs-

ing assistance when giving bedside care to infirmary patients, thus avoiding twenty-four hour nursing service with resultant fatigue.

7. Adequate clerical help is essential for administrative efficiency.

8. Unless otherwise administered, the college nurse should by reason of her professional training, take an active part in the formal health-education program of the college.

9. A greater uniformity of descriptive titles for college nurses will more adequately indicate the type of services rendered.

10. Greater uniformity of salary scale, with salary increases sufficient to conform to salaries of other offices entailing a similar amount of educational and professional background and responsibilities, will make the service more attractive to nurses who are well prepared for the work.

THE AMERICAN JOURNAL OF NURSING FOR MAY

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THE NURSING BUREAU OF MANHATTAN AND BRONX, INC.

ONE HUNDRED and ninety-two new positions in public health nursing were registered by The Nursing Bureau of Manhattan and Bronx from April 1 to December 31, 1939. This is an encouraging report, since the public health nursing placement service was only begun on April 1, 1939, and was approved for the use of public health nurses by the National Organization for Public Health Nursing on December 16, 1939.

The Bureau registered 277 public health nurses during this period, which was 21.3 percent of the total number of registrants.* Fifty-six public health nurses—or 7.6 percent of the total placements* made by the entire Bureau—were placed in positions.

Positions were registered from 21 states, Canada, and the District of Columbia. In general the spread of new positions follows the lines that one might expect of a new service centered in New York City. It is greatest in the city itself. New York State is next in order of frequency, followed by neighboring states—Connecticut, New Jersey, and Pennsylvania—and a gradually decreasing number from north to south with a scattered few toward the west.

The slow placement in all types of positions, according to Letha Allen, the vocational secretary for public health nursing, mirrors the slow turnover characteristic of public health nursing. It also indicates the increasing emphasis on qualifications, with careful selection of candidates, and the dearth of well qualified nurses. While all these factors operate in positions of all levels, the lack of well qualified nurses is felt most keenly in the mid-level—nurses prepared

to work without supervision. A slow and careful selection is most marked in higher level positions.

The relatively small number of placements in proportion to requests is partly symptomatic of the newness of the service, and the fact that publicity has reached the employing agencies more rapidly than the nurses. It is even more due to the fact that many nurses do not feel the need of a placement service when they are able to obtain positions through the many informal placement services of nursing agencies and universities. Somehow the nurse must be convinced that her chance of obtaining the kind of position best suited to her needs will be increased through registration with a professional placement service rather than by canvassing the field herself. At the same time, it would seem necessary to persuade many of the schools and agencies running their small informal placement services that it would be more efficient and to the best interest of public health nursing for them to permit the professional placement services to carry on much of their work for them—in recruiting nurses, making a preliminary selection, collecting credentials, and assembling professional histories. Only the final interviewing and selection would then be left for them to do. The American Red Cross Nursing Service has set a fine example in this respect.

Every effort has been made to coordinate the work of the Bureau with that of the Nurse Placement Service in Chicago. The same form for the applicant's personal record is used; credentials of applicants are freely exchanged; conferences have been held; and the relation between the two services has been explained to nurses.

*Exclusive of private practice.

In Memoriam

*Some shining April I shall be asleep,
And over me the ancient joy shall pass;
I shall not see young Spring dance down the world
With ribbons of green grass.*

*But I shall dream of all that I have lost—
Breath of the wind, immortal loneliness,
Wild beauty of the sunlight on the hills,
Now mine no less.*

*Because I slumber. Nay, but more than mine,
Since I a part of them shall strangely be.
Only I ask, when the pink hawthorn breaks
That one shall think of me.*

The Last Sleep by Charles Hanson Towne from Harper's Magazine.

Again in May we are listing those public health nurses who have died during the last year, and as before we are requesting our readers to send us word when any of our number pass from among us.

Alice Baker, May 3, Calistoga, California.

Ruth Banker, August 19. Continental Can Company, Chicago, Illinois.

Marie H. Buch, December 15. Egg Harbor, New Jersey.

Sara Katherine Butler, July 18. Harrisburg, Pennsylvania.

Lulu V. Cline, March 24. Director, Department of Health, Public Schools, South Bend, Indiana, and Chairman, School Nursing Section, American Association for Health, Physical Education, and Recreation, a department of the National Education Association.

Cora A. Curtis, Orleans, Vermont.

Laura A. Gamble, March 21, 1939. Ontario, Canada. Formerly (1924) Director, Bureau of Nursing, Cattaraugus County Rural Health Demonstration, New York.

Grace Hobson, Sacramento City Health Department, Sacramento, California.

Anna B. Heldman,* March 15. Director, Personal Service Department, Irene Kaufmann Settlement, Pittsburgh, Pennsylvania.

Mrs. Nellie Jones, Lincoln Parish Health Unit, Ruston, Louisiana.

Mrs. Lillian Sauer Latimer, January 1. Dubuque, Iowa. Former member of staff of Dubuque Visiting Nurse Association.

Margaret A. Little, November 18. Worcester Society for District Nursing, Worcester, Massachusetts. A member of the N.O.P.H.N. since

January 1913, one year after the N.O.P.H.N. was organized.

Grace MacIntyre, May. School District, Clairton, Pennsylvania.

Julia Mellichamp, November 24. Charleston, South Carolina.

Mrs. Helen S. Metzger, February 1, 1938. Brooklyn, New York.

Mrs. Orpha Drew Morris, Metropolitan Life Insurance Company, Los Angeles, California.

Hortense Murry, May 5. County Nurse, Hampton, Arkansas.

Emma Nelson, February 1. Passaic, New Jersey. School nurse with Passaic school system for 21 years.

Bertha Patterson, March 5. State Department of Public Health, San Diego, California.

Margaret Paul, October 26. Director, Visiting Nurse Association of Eastern Delaware County, Lansdowne, Pennsylvania.

Elizabeth Ross, April 5. Director, Health Center of the Brookline Friendly Society, Brookline, Mass. Former President, Massachusetts State Nurses' Association and First Vice-president, Massachusetts Organization for Public Health Nursing, 1938-39.

Susan Strickland, January 5. Thomas County Health Department, Thomasville, Georgia.

Bessie Harrington Sloggett, July 7. Evanston, Illinois.

Mrs. Katherine Beaton Thomas, February 20. Portland, Maine. Mrs. Thomas came from Scotland in 1900 and was the first nurse employed by the Portland District Nursing Association.

Mrs. Jean H. Watson, March 18. County nurse, Ontonagon, Michigan.

* See September 1939 issue, p. 522.

Your N.O.P.H.N.

The gems of Being
Cannot be extracted
From the matrix of existence
Save by the pickax of experience.

—Mary Cummings Eudy*

THE SCHOOL Nursing Section of the National Organization for Public Health Nursing is primarily concerned with the scope, functions, and preparation of the public health nurse in relation to the well-being of the school-age child. If we compare the trends in school nursing yesterday with those of today, we will find that the scope and functions of the school nurse have broadened tremendously—as have the functions of every other public health nurse. Formerly school nursing was not only quite detached from every other function of the school, but also quite isolated from other community nursing and health activities. In the early days the school nurse was usually—but not always—a graduate, registered nurse.

Today, she is a graduate, registered nurse with academic preparation and experience in the general field of public health nursing and specialized preparation in the field in which she is functioning. With her broadened background and experience have developed the recognition of the family as a unit, a better understanding of human behavior, a closer coördination of all health services in the community, increasing lay participation in school nursing, closer working relationships between the nurse and all school personnel, and an awareness of all problems of nursing.

The objectives of the School Nursing Section are first "to maintain high professional standards for nurses who are engaged in school nursing; second, to study the physical needs of the school

child and help to promote methods for raising health standards."**

Just how does the N.O.P.H.N. proceed toward the accomplishment of these objectives? The School Nursing Section is composed of those members of the Organization who are interested in or concerned with the school-age child. About a month before the Biennial Convention, a card is sent to all members of the N.O.P.H.N. giving them the privilege of voting for the officers of the section in which they are most interested. In this way the membership has an opportunity to participate in the activities of the sections. The executive committee of the School Nursing Section includes national leaders in school nursing and related fields of nursing and education. Through its committees it studies relationships and recommends policies and practices which are important in this phase of public health nursing. At present there are five committees active on various projects.

1. The Subcommittee on School Nursing Records is preparing an individual health record and monthly report form for school nurses. After the forms have been completed they will be submitted to the Records Committee of the N.O.P.H.N. for recommendations and approval. The next step is trial in a variety of communities. The N.O.P.H.N. will welcome volunteers to try out these record forms before they are put into permanent form for use in the country as a whole.

2. The Subcommittee on School Nursing Procedures has prepared a form entitled "log of a school nurse's day," which will be used as the basis of a study of current practice in school nursing. If you would like to participate in this study, please let us know.

3. The Subcommittee on College Nursing is studying the activities of nurses responsible for the health pro-

*From *Quarried Crystals and Other Poems*. G. P. Putnam and Sons, New York.

**From Bylaws of the N.O.P.H.N. School Nursing Section.

grams in colleges throughout the United States.

4. The Subcommittee on School Nursing Field Practice was organized to review current practice in university programs of study in public health nursing concerning the content of the school nursing program of study.

5. The Subcommittee to Prepare and Supply Information on Content of the School Nurse's Home Visit is the infant of the School Nursing Section. The plan is to ask small groups of nurses to prepare material which will help the nurse solve the problems she is called upon to meet in her daily work.

It may seem that there is a wide gap between the work of the committees and the practical problems encountered by the individual nurse in her own sphere of influence. But this is not true. The results of committee efforts are discussed in *PUBLIC HEALTH NURSING* magazine and are thus available to all public health nurses. In every issue throughout the school year the magazine includes timely articles of interest to the school nurse. Reprints of many of these are available free of charge to members of the organization. In addition, membership in the N.O.P.H.N. gives the nurse the privilege of participation in formulating policies and standards, helps keep her up to date, and gives her voting privileges.

A glance at a few letters will give an inkling of the type of questions referred to the secretary of the School Nursing Section, who is a member of the N.O.P.H.N. staff:

"Will you give me some suggestions concerning my school program? I have accepted a new position recently."

"Will you send me information about the newer method and trend in making morning health inspections?"

"Please send me suggestions for health projects for college students."

"Will you send me the following information about school nursing: (1) the nature of the work (2) the preparation

that is required and where the preparation can be obtained (3) the income received for such work?"

"Will you tell me whether there are any scholarships or stipends available to school nurses?"

Thus through correspondence many nurses secure personal and individual help in their daily work.

Another major activity which helps in the attainment of the objectives of the School Nursing Section is participation in the National Biennial Nursing Convention. A series of group conferences, any one of which will be helpful to the school nurse, has been planned for May 11 and 12 of this year, in Philadelphia. (See April issue.) Since attendance at these conferences is limited, early registration is essential. The entire week of May 12 is literally packed with events which will be of value to the school nurse. The joint program is published in the March issue, page 213. The final N.O.P.H.N. program appeared on page 275 of the April issue.

Thus the N.O.P.H.N. strives to meet its objectives through the work of its committees and by helping the individual nurse with her practical problems through correspondence, office conferences, field visits, timely articles in the magazine, and the Biennial Convention. It also represents school nurses in allied national groups. These include the Health and Physical Education Section of the National Education Association, the National Conference for Coöperation in School Health Work, the American School Health Association, the Progressive Education Association, the National Tuberculosis Association, the American Public Health Association, and the Educational Policies Association.

As one of our many correspondents recently said, there are "a lot of functions, to be sure"; we need the active participation of every single nurse to make these objectives become realities.

ANNA C. GRING
Assistant Director

NOTES *from the* NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

LIFE MEMBERSHIP

As soon as life membership in the N.O.P.H.N. was made possible by the revision of the N.O.P.H.N. bylaws, many public health nurses and laymen availed themselves of this type of membership. Twenty-five of the 77 memberships to date have been given to individuals as honorary gifts by staffs, boards, other nursing groups, and individuals. The first to enroll was Mrs. S. Emlen Stokes, a lay member of the N.O.P.H.N. Board of Directors, on March 13, 1934. She was followed very closely by our own general director, Dorothy Deming—who was at that time editor of *PUBLIC HEALTH NURSING*—on March 30, 1934. We are hoping to add many names to the following list of nurses and laymen and are planning to publish them in the magazine from time to time. The fund—\$7700 to date—is invested to be used at some future time, only by special vote of the Board of Directors. Interest is used for current expenses.

Connecticut

Mrs. A. Victor Barnes
Rachel C. Colby
Mrs. Alfred E. Hammer
Lillian D. Wald

District of Columbia

Mary Beard
Gertrude H. Bowling
Naomi Deutsch
Mrs. Saidie Orr Dunbar*

Georgia

Margaret Brinkman

Illinois

Eula B. Butzerin*
Dorothy Rood
Christine M. Scully

Indiana

Cleo L. Harter**

Kansas

Esther M. Latimer

Maine

Edith L. Soule*

Maryland

Ada M. Carr*

Massachusetts

Dorothy J. Carter
Harriet E. Clarke
Mrs. F. S. Dellenbaugh, Jr.
Rosebelle Jacobus*
Sophie C. Nelson
Gertrude W. Peabody*†

Michigan

Mrs. Lystra Gretter*
Ella McNeil
Grace Ross*
Emilie G. Sargent*
Dr. Henry F. Vaughan*
Marguerite A. Wales

Minnesota

Laura A. Draper
Mrs. James E. Kelly
Olivia T. Peterson

Missouri

Emilie G. Robson*

New Jersey

Mrs. Chellis A. Austin
E. C. Carter
Mrs. Russell Colgate
Dorothy Deming
Mrs. Charles F. Nicholson
Mrs. Robert Rushmore
Mrs. S. Emlen Stokes
Mrs. Roger Young

New York

Mrs. David H. Ball
Dr. Michael M. Davis
Mrs. Anne L. Hansen*†
Alma C. Haupt
Ruth Houlton
Mrs. Shepard Krech
Mrs. John M. Satterfield
Arline Shaw
Elizabeth Stringer
Mary Elizabeth Tennant

Ohio

Loneta M. Campbell*

*Honorary gifts.

**Award made by N.O.P.H.N. to winner of membership essay contest.

***Latest life membership to the N.O.P.H.N., the gift of the state health officers and public health nurses of North Dakota.

†Deceased.

Augusta M. Condit*
Elizabeth M. Folckemer*
Grace S. Frost*
Marion G. Howell
Mrs. R. L. Ireland
Emma Elizabeth Roberts*
Cora M. Templeton*
Jane L. Tuttle*

Pennsylvania

Mrs. Anna Reis Barlow*
Mary Cameron
Ruth W. Hubbard
Mrs. Isidore Kohn
Helen Stevens*
Katharine Tucker

Rhode Island

Mrs. Gammell Cross
Nellie R. Dillon*
Winifred L. Fitzpatrick*
Mary S. Gardner
Eleanor B. Green

Tennessee

Aurelia B. Potts*

Washington

Minnie Heuerman

Wisconsin

Norma A. Johannis**
Florence M. Patterson
Cornelia Van Kooy*

China

Anna Katharine Zierdt

Denmark

Margrete Skaarup***

WITH THE STAFF

Dorothy Deming continued her trip on the West Coast during the first part of March. She attended regional meetings in Oregon and Washington to discuss with board members and public health nurses some of their problems in relation to the N.O.P.H.N. program of service in the field. From March 3 to 6, she was in Portland, Eugene, and Oregon City, Oregon. From there she went to Washington, visiting Tacoma, Seattle, and Spokane from March 7 to 12. She returned to the N.O.P.H.N. office on March 18.

On April 3, she went to New Haven, Conn., to speak to the students at the Yale School of Nursing. She spoke at the twenty-fifth anniversary tea of the

Visiting Nurse Association of Plainfield, N.J., on April 11. On the nineteenth she attended the twenty-fifth anniversary meeting of the New Jersey State Organization for Public Health Nursing in Asbury Park and extended greetings from the N.O.P.H.N.

Ruth Houlton made a few short field trips during March. She conferred with the Lay Section of the New Jersey S.O.P.H.N. in Trenton on March 15. She spoke at the institute for students held under the auspices of the National Tuberculosis Association at the Yale School of Medicine in New Haven on March 20. She went to Bridgeport, Conn., on March 28, to speak to the lay group at the Connecticut State Nurses' Association meeting.

She made only one trip during April, going to Hartford, Conn., on the eighteenth to speak on evaluating the effectiveness of a public health nursing service, at the tenth New England Health Institute held under the auspices of the New England Public Health Association.

Evelyn Davis continued to conduct discussion meetings in the Middle West. She spent the week of March 11 in Idaho, holding discussion meetings in regard to lay committees for public health officers, nurses, and lay people in Pocatello, Twin Falls, Boise, Lewiston, and Coeur d'Alene. From Idaho she went to South Dakota from March 19 to 22 to hold the same type of meetings in Huron and Rapid City. She gave a talk on "The Layman's Part in Furthering Community Nursing Service" at the joint dinner meeting of the Council of Social Agencies and the Community Council on Nursing, in Duluth, Minn., on March 25. She spent March 26 in St. Paul, Minn., conferring with the director of the Family Nursing Service; and March 27 giving consultation service to the Community Health Service in Minneapolis, Minn. On March 29, she gave a talk at the dinner meeting

on laymen's day at the Minnesota S.O.P.H.N. in Minneapolis. She returned to headquarters on April 3.

She went to Springfield, Mass., on April 26 to speak at the spring conference of the New England Conference of Chests and Councils.

Virginia Jones spent the month of April in the field. She went to Syracuse, N.Y., on April 4 and 5 to visit the program of study in public health nursing at the University of Syracuse. From there she went to Cleveland, Ohio, visiting the program of study in public health nursing at Western Reserve University from April 6 to 9. On April 12, she attended the meeting of the Board and Committee Members' Organization for Public Health Nursing in Akron, Ohio, and on the thirteenth, she spoke on the education of the nurse for public health nursing today, at the Annual Convention of the Ohio State Nurses' Association in Akron. From there she went to Bloomington and Indianapolis, Ind., visiting the program of study in public health nursing at the University of Indiana from April 15 to 17. She visited the program of study in public health nursing at the University of Michigan in Ann Arbor on April 18 and 19.

Jessie Stevenson conducted a field conference on orthopedic nursing under the sponsorship of the U. S. Children's Bureau in New Orleans, La., from March 4 to 7. She spent the week of March 11 making an observation trip through South Carolina. She gave another field conference on orthopedic nursing under the sponsorship of the U. S. Children's Bureau and the Kentucky Crippled Children's Commission in Louisville the week of March 25.

HONOR ROLL

Is your agency on the 1940 Honor Roll? If it doesn't appear on this list or previous ones published in 1940, you can easily assure its being among those listed next month.

All you have to do is have your staff 100 percent enrolled and then let us know. Don't be afraid to brag a little about it to us for it's certainly good news and serves as a signal for us to send your Certificate of Honor to you.

The Honor Roll goal is 1000! We need each one of you—whether one-nurse service or several—to help us achieve this in 1940.

ALABAMA

Chambers County Health Department,
LaFayette
Metropolitan Life Insurance Nursing
Service, Montgomery
Dallas County Health Department, Selma
Bullock County Health Department,
Union Springs

CALIFORNIA

Metropolitan Life Insurance Nursing
Service, Sacramento

COLORADO

Colorado College, Colorado Springs

CONNECTICUT

*Public Health Nursing Association of
Easton, Bridgeport
*Fairfield Visiting Nurse Association, Fair-
field
Metropolitan Life Insurance Nursing
Service, Torrington

GEORGIA

Savannah Sugar Refining Corporation,
Savannah

ILLINOIS

Beardstown School and Community
Nursing Service, Beardstown
Village of Hinsdale Health Department

INDIANA

Evansville Public Schools, Evansville
Marion County Board of Education,
Indianapolis
*Public Health Nursing Association,
Richmond

IOWA

*Lyon County Public Health Nursing
Service, Rock Rapids

KANSAS

*Wichita Public Health Nursing Associa-
tion, Wichita

KENTUCKY

Metropolitan Life Insurance Nursing
Service, Henderson

LOUISIANA

Baton Rouge Chapter, American Red
Cross, Baton Rouge

*Agencies which have been on the Honor Roll
for five years or more.

St. Mary Parish Health Center, Franklin

MAINE

Southwest Harbor-Tremont Nursing Association, Southwest Harbor

MARYLAND

Anne Arundel County Health Department, Annapolis

MICHIGAN

Benton Harbor Public Schools Health Service, Benton Harbor

Out Patient Nursing Service, Harper Hospital, Detroit

*Community Health Service of Grand Rapids, Grand Rapids

Muskegon County Health Department, Muskegon

MINNESOTA

City Health Department, Duluth

*St. Paul Family Nursing Service, St. Paul

MISSOURI

State Board of Health of Missouri—District No. 11, Cameron

Missouri Tuberculosis Association, St. Louis

Clark County Public Health Nursing Service, Kahoka

NEW JERSEY

Central Bergen Visiting Nurse Service, Hackensack

NEW YORK

Seneca Falls Metropolitan Life Insurance Nursing Service, Geneva

Metropolitan Life Insurance Nursing Service, Glens Falls

Metropolitan Life Insurance Nursing Service, Lockport

Oyster Bay Visiting Nurse Association, Oyster Bay

*Dutchess County Health Association, Poughkeepsie

*Public Health Nursing Association, Inc., Rochester

NORTH CAROLINA

*Metropolitan Life Insurance Nursing Service, Charlotte
City Health Department, High Point

OHIO

Cleveland Child Health Association, Cleveland

Visiting Nurse Association of Cleveland—Branch No. 1, Cleveland

*Western Reserve University Public Health Nursing District, Cleveland

RHODE ISLAND

*Jamestown Chapter, American Red Cross, Jamestown

New England Telephone and Telegraph Company—Medical Department, Providence

Providence Health Department, Providence

TENNESSEE

Upper Cumberland District Health Department, Livingston

Shelby County Health Department—Nursing Division, Memphis

TEXAS

Milam County Public Health Board, Cameron

Liberty County Health Department, Liberty

Tyler-Smith County Health Unit, Tyler
Wichita County Chapter, American Red Cross, Wichita Falls

Houston Visiting Nurse Association, Houston

VERMONT

Visiting Nurse Association, Burlington

*Metropolitan Life Insurance Nursing Service, Rutland

WISCONSIN

Oshkosh Visiting Nurse Association, Oshkosh

BIENNIAL CONVENTION, MAY 12-18**APPROXIMATE BUS RATES TO PHILADELPHIA**

	One way	Round trip
Boston, Massachusetts.....	\$ 5.15	\$ 9.30
Chicago, Illinois.....	13.95	25.15
Cleveland, Ohio.....	8.00	14.40
Newark, New Jersey.....	1.65	3.00
New York, New York.....	1.75	3.15
Parkersburg, West Virginia.....	7.65	13.80
Pittsburgh, Pennsylvania.....	5.50	9.90
Portland, Maine.....	6.90	12.45
Providence, Rhode Island.....	4.70	8.50
Richmond, Virginia.....	4.80	8.65
St. Louis, Missouri.....	14.80	26.65
Syracuse, New York.....	5.25	9.45
Washington, District of Columbia.....	2.55	4.60
Wilmington, Delaware.....	.50	.90

ADDITIONAL HOTEL FACILITIES IN PHILADELPHIA

Hotel	Accommodations	Rates
Central Y.W.C.A. 1800 Arch Street	Single room	\$1.00 to \$1.50
Crozer Hall 2039 Cherry	Single room	1.00 to 1.25
Tracy 36 and Chestnut	Single room, with bath	2.00
	Double room, with bath	3.00 up
	Three in a room, bath	4.00 up
	Suite, parlor, bedroom, bath (will accommodate 3 to 5 persons)	4.50 up
Whittier Hotel 140 North 15 St. (formerly Young Friends' Associa'n)	Single room, running water	1.50 to 2.00
	Single room, private bath	2.50
	Double room, running water	3.50 to 4.00
	Double room, private bath	5.00
Warburton 20 and Sansom	Single room, running water	2.00
	Single room, private bath	3.00
	Double room, private bath	5.00
Marlyn 40 and Walnut	Single room with bath	2.00
	Double room with bath	3.50
	Single parlor, bedroom, bath	3.00
	Double parlor, bedroom, bath	4.00 to 4.50

The Committee on Housing, of which Sarah Krewson, 2350 East Sergeant Street, Philadelphia is chairman, will be glad to make reservations but it will be better to write directly to the hotels for reservations.

For other hotels see December 1939 issue, page 711.

APPROXIMATE AIR RATES TO PHILADELPHIA

	One way	Round trip
Atlanta, Georgia	\$43.80	\$78.80
Boston, Massachusetts	16.30	29.30
Charleston, South Carolina	35.10	63.10
Chicago, Illinois	40.15	72.26
Cleveland, Ohio	23.20	41.76
Dallas, Texas	78.30	140.94
Denver, Colorado	91.62	164.90
Ft. Worth, Texas	78.30	140.94
Jacksonville, Florida	47.15	84.90
Kansas City, Missouri	61.65	110.96
Los Angeles, California	145.15	261.26
Milwaukee, Wisconsin	44.30	78.91
Minneapolis, Minnesota	56.65	99.76
Newark, New Jersey	4.35	7.80
New Orleans, Louisiana	69.50	125.10
New York, New York	4.35	7.80
Omaha, Nebraska	64.65	116.36
Portland, Oregon	139.15	232.26
St. Louis, Missouri	48.70	87.66
Salt Lake City, Utah	114.10	205.36
San Antonio, Texas	93.30	167.94
San Francisco, California	145.15	261.26
Seattle, Washington	139.15	232.26
Tampa, Florida	61.35	110.50
Washington, District of Columbia	7.85	14.10

It is requested that nurses do not visit hospitals until Saturday, May 18, or the day after the Biennial Convention closes. There is one exception to the above notice. The Navy Hospital wishes visitors all the week. Trips going out with special transportation will be scheduled and posted.

TRANSPORTATION CHAIRMEN

Most of the state chairmen on transportation were listed in the February issue but the following have recently been appointed:

Harriott L. P. Friend, Director at Headquarters, State Nurses' Association, 609 Sutter Street, San Francisco, Calif.

Frieda Roerden, Secretary, State Nurses' Association, Homeopathic Hospital, Wilmington, Del.

Jean Thomson, Secretary, State Nurses' Association, 1212 Washington Street, Boise, Idaho.

Edith Bergquist, Executive Secretary, State Nurses' Association, 8 South Michigan Avenue, Chicago, Ill.

Mrs. Myrtle C. Applegate, Executive Secretary, State Nurses' Association, 604 South Third Street, Louisville, Ky.

Bertie G. Jones, President, State Nurses' Association, City Hospital, Cleveland, Miss.

Avis Purdy, Clarkson Memorial Hospital, Omaha, Nebr.

Mrs. Florence L. Mayer, Secretary, State Nurses' Association, 314 Seventeenth Street, Sparks, Nev.

Mrs. Sylvia Hoover, St. Vincent's Sanatorium, Santa Fe, N. Mex.

Nellie C. Cunningham, Executive Secretary, State Nurses' Association, 306 Carolina Life Building, Columbia, S. Car.

Alice Olson, Box 813, Huron, S. Dak.

Glee G. Martin, Executive Secretary, State Nurses' Association, Room 1000, Textile Tower, Seattle, Wash.

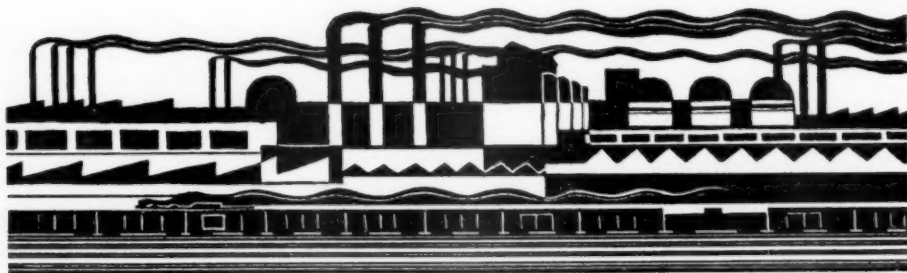
May M. Maloney, Executive Secretary, State Nurses' Association, Capital City Building, Charleston, W. Va.

REGISTRATION AT THE BIENNIAL

General registration will be held at the Benjamin Franklin Hotel, Philadelphia, Sunday, May 12, 10:00 a.m.-5:00 p.m., and in Convention Hall, 34 Street and Vintage Avenue, May 13-16. Registration hours for the week will appear in the printed program. Registration for A.N.A. delegates and for members of the Private Duty Section of the A.N.A. will take place at the Benjamin Franklin Hotel on Sunday, May 12, 10:00 a.m.-5:00 p.m.



Photo-Illustrators, Philadelphia
Washington's Headquarters at Valley Forge, Pennsylvania



Management Looks at Industrial Nursing

INDUSTRIAL nursing service should have the unqualified support of every forward-looking executive. It is one of the greatest builders of good will in existence today. The value of the personal contact between the nurse—a company representative—and the employee at the time he needs help and care is inestimable. There is no substitute for this personal contact. The benefits of industrial nursing to industry can be summarized as follows:

- It is a builder of good will.
- It makes a satisfied employee.
- It increases the efficiency of workers.
- It reduces the costs of production.

Here are a few of the problems confronting management in regard to a health department in industry:

- How big shall the department be?
 - Complete first aid room
 - Full-time nurse
- What are the qualifications of a good nurse?
- Where can I obtain such a person?
- To whom shall she be responsible?

There are many other questions in the establishment of an adequate first-aid and industrial nursing staff, but to me these are the most important. I would place the question of qualifications for a good nurse first in order of importance. The selection of the proper individual to carry on this good will work and to practice her profession with efficiency

By JOSEPH M. CONWAY

means the difference between success and failure.

Let us for the moment make believe that we are workers in a large industrial plant, and that we have been injured and are being taken to the first-aid station. What kind of a place would you like to be taken to? What kind of an individual would you like to meet upon your arrival? Would you willingly place yourself under her care knowing that you would be given the best care and advice possible?

On the way down our minds would work something like this: "I'm glad Miss Smith is here instead of that substitute nurse we had for the past two weeks. Everyone said she was a terror—blamed you for everything; said you were careless, indifferent, didn't care. Miss Smith isn't like that. She is tough on us when the accident ratio slips, but her approach takes the sting out of it. She has tact and diplomacy and she really likes all of us—works hard to keep us and our families safe and healthy. She is a graduate nurse and keeps up on all the latest methods. It won't take her long to fix me up. She won't say much to me, but I know what she will be thinking, because just last week at the safety meeting she told us to be careful

of loose clothing—neckties, large cuffs, and so forth.”

You would begin to feel sorry—not for yourself, but for that kind, friendly nurse who has tried so hard to keep you from injury. You let her down. You broke her record. You caused a lost-time accident in her department. If Miss Jones, the temporary nurse, were on duty, your blood pressure would probably rise to tremendous heights. But knowing Miss Smith is on duty, although naturally you are a bit excited, you are in a much better mood and position for recovery. You are much more receptive to correction and your determination not to be a second offender will be much stronger if the approach, the time, and setting are just right.

Now you enter the first-aid room. Miss Smith is there to greet you. She knew you were coming and has everything ready. No “bawling out,” no unnecessary conversation. That can come later. Now there is a job to do. Miss Smith, as you watch her, is a young lady without a doubt in the best of health. She is neat in her appearance and house-keeping. She knows her duty and goes about it with an air of professional dignity to be marveled at. She makes you comfortable and dresses your wound. When everything is done, she sits down beside you to hear your story, and takes notes which will be used, not to crucify you at the next safety meeting, but to consider the accident in the light of what has happened and how it can be avoided in the future. An accident to her means a failure on the part of someone or something to act in accordance with expectations. This failure must not recur.

This ability to win your confidence now enables you to tell your story truthfully. You don't have to lie to Miss Smith, or put the blame on someone else. She understands that people do get hurt, but her job is to find out why and correct it as soon as possible. You

are now ready to leave, but her work has just begun.

This story brings out those things which are so necessary in a successful industrial nurse. She should have tact. She should be forceful. Yet she should command the respect of the worker and employer. She must be efficient and keep abreast of latest developments in safety and medicine. She should never feel that she is established for life in an industry or be satisfied with knowing enough to handle the ordinary injuries in a day's work. She must without a doubt have the full loyalty and coöperation of the employees. They must be convinced that she is there for their good and for the good of their families, who suffer when the worker is out of employment temporarily or dead. They must be taught and made to feel that an ounce of prevention is better than a pound of cure.

A good nurse will rise above petty things and will be impartial in her dealings with the employer and employee. She is the so-called go-between with employees, for both the employer and the insurer. As contact person she must have their confidence that they will be justly treated and willing to do what she asks them to do. She must be thoroughly familiar with every department in the plant—every hazard and every piece of machinery.

These qualifications can be summarized as follows:

She must be interested in and able to understand people.

She must have personal strength of character.

She must have initiative, be democratic, and perform her job with enthusiasm and geniality.

She must have common sense and good judgment; must be smiling and encouraging.

She must have an inquiring mind to find the facts without submitting the patient to a third degree.

She must think objectively—from the point of view of herself, the company, and the employee.

All the money in the world spent in

equipment and buildings will be productive of nothing if we do not have the proper individual at the head of the department. Where can we obtain such an individual? Such women are found through professional placement agencies* or through the company physician, who has numerous contacts. In this line of work, experience is a prime essential. It relieves the management of the responsibility of initiating an industrial nurse into her duties, and allows more time for establishing policies and getting things done.

TO WHOM IS NURSE RESPONSIBLE?

To whom shall the company nurse be responsible? There does not seem to be much doubt in the mind of management that a department of such importance from the standpoint of health and accident-prevention and good will should be directly responsible to the president of the organization. This policy allows it the maximum of freedom from business politics and enables it to act free from the influence of department heads or superintendents. This does not mean that all individuals concerned are not consulted on industrial nursing policy, but it does mean that the first decision on any matter rests with the president of the corporation.

What shall be the size of the first-aid department and personnel? If an organization has the right kind of a president and employs the right individual for the industrial nurse, the size of the department will take care of itself, because it will be conducted with intelligence and foresight with a view to taking care of all necessities.

Industrial nursing is not to be shunned and avoided, but to be eagerly sought. It benefits the employee and the em-

ployer alike. The lives and limbs of men are precious. We have them once and once only. If lost, they are lost forever. Anything dealing with either or both—especially when the individual is on our property or working in our plant—is a great responsibility that we as employers cannot neglect.

Millions of hours of work each year are lost through minor accidents, both on and off the job; through colds and sicknesses of various sorts. Industrial injuries alone, according to the U. S. Bureau of Labor Statistics, cost industry over two billion dollars in 1937.* Much has been accomplished in past years in the reduction of lost time and lowered productive efficiency due to these causes.

Our experience and results with industrial nursing have been very gratifying. The saving in insurance premiums more than offsets the cost of operating the department and we have the satisfaction of knowing that our employees like their work; that they work for us because they want to and not because they have to. Our safety and health program which has won more than one trophy for us is a big contributing factor in the peace of mind of our employees. A man who has been injured is a scared worker for quite a while and during this time his efficiency is greatly impaired.

SCOPE OF INDUSTRIAL NURSING

There is, however, one controversial question which arises in regard to industrial nursing, just as it arises in many other ways regarding the relationship of employer and employee. How far should it go? Some industries do not believe in being paternalistic and extending the nursing services to the employees and their families. Others practically take care of everyone and everything. Each firm should study its own

*NOTE: The two professional placement services approved by the National Organization for Public Health Nursing are the Nurse Placement Service, 8 South Michigan Avenue, Chicago, Illinois, and The Nursing Bureau of Manhattan and the Bronx, 205 East 42 Street, New York, N.Y.

* Kossoris, Max D. A Statistical Approach to Accident Prevention. (Mimeographed.) U. S. Bureau of Labor Statistics, Washington, D.C., 1939.

situation and draw a line somewhere. Many employees feel that their home is their kingdom and that they alone reign supreme after the quitting whistle blows. Others welcome the helpful service and advice. Perhaps a happy medium of giving advice and help when asked will prove the best.

This is a big question and unless it is properly solved, it will sooner or later become the source of trouble and dissatisfaction. The experience of others does not help us much. Some have succeeded where others have failed. Each of us must work out his own solution.

The future of industrial nursing is what you as nurses make it. If you take your job in earnest and "dig in" and get results, the service is bound to grow. If you take the lines of least resistance and limit your work to dressing wounds and giving out pills, you are just as surely doomed to failure.

You have the backing of management.

They have confidence in your ability to help them. What you do with this backing and confidence—what you do with the future of your profession is entirely up to you. The industrial nurse has a right to expect the following help and coöperation from management: a definition of the scope of the duties and responsibilities of her department; complete freedom of action within those limits; complete coöperation in enforcing safety rules and regulations. Insofar as it is possible she should be furnished with comfortable convenient quarters, large enough for the needs of the plant. All of these requirements are important. Without them she cannot hope to succeed. Management wants, and has a right to expect results, but it must also be willing to do those things which make results possible.

Presented before the Industrial Nursing Section, National Safety Congress, Atlantic City, New Jersey, October 19, 1939.

CAPITAL LETTERS ARE HARD TO READ

The practice of capitalizing words merely for the sake of emphasis is a common one. Advertisers, especially, tend to use capitals for emphasis, although there is a modernistic trend to use small letters. Nurses who prepare mimeographed or printed materials for education in health and safety will be interested in the following excerpt from the *American Journal of Public Health*, April 1937:

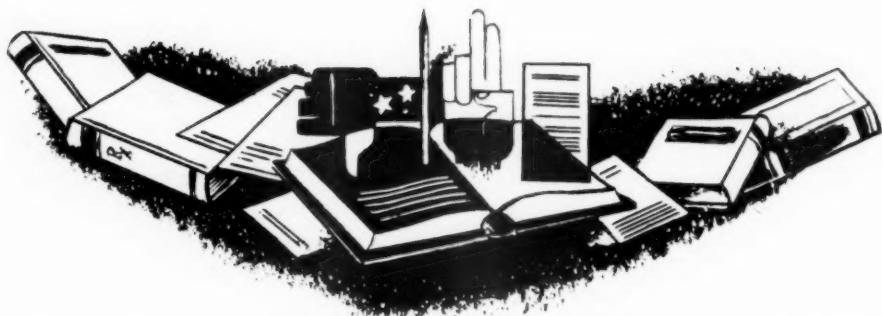
Long ago advertising psychologists tested and proved that capital letters are

hard to read. In other words, every letter capitalized in the word or sentence to emphasize its importance actually reduces its legibility.

The other day we saw two striking displays put up by a health department. All letters were capital letters. All capital letters are hard to read.

Most road signs are in all caps—and so they are harder to read than if lower case were used. Make lower case letters as large as the caps, and they will be as easily seen, and more easily read.

The first annual meeting of the American Industrial Hygiene Association will be held at Hotel Pennsylvania, New York City, June 4 and 5. For information write Mr. N. Bernz, Fidelity and Casualty Company, 80 Maiden Lane, New York City.



EDITED BY ANNA C. GRING

A COLLEGE COURSE IN HYGIENE

By K. Frances Scott, M.D. 202 pp. The Macmillan Company, New York, 1939. \$2.50.

In this book the author has blended in a most interesting way the anatomy, physiology, and hygiene of the human body, and has shown the individual's relationship to the community in a unique manner. The content and style are adapted to the needs and interests of the adolescent group. The simple statements of scientific facts are not only instructive but tend to stimulate interest in further study. The development proceeds in logical sequence and each division is complete with brief historical data and first-aid suggestions. The chapters on mental and sex hygiene are particularly timely and well handled.

The text has been addressed to girls, which may have a tendency to limit its use as a textbook in coeducational institutions. Nevertheless, it will be a valuable aid to any instructor who wishes to present the individual as an integrated part of his environment.

OLIVE J. FAULKNER, R.N.
Laramie, Wyoming

TOWARD MENTAL HEALTH IN SCHOOL

By C. Roger Myers, Ph.D. 151 pp. University of Toronto Press, Toronto, Ontario, Canada, 1939. \$1.50.

Dr. Myers offers an introduction to mental hygiene as it comes within the teacher's professional experience. Free from technical terms and limited to the

factual and illustrative material which will most directly help the teacher, the book will be read through and understood. The subtopics in each chapter attract the reader's attention and an adroitly-introduced bibliography increases the value of this book. It will interest parent-teacher groups and medical and nursing speakers who want an example of masterly simplification.

ANNE POORE, R.N.
Des Moines, Iowa

TEACHING WHOLESOME LIVING

By Alma Dobbs. 304 pp. A. S. Barnes and Company, New York, 1939. \$2.50.

At last it has happened! my mind kept repeating over and over as I read the preface and Part I of *Teaching Wholesome Living* by Alma Dobbs. At last a "health book" of the way a child grows—in all ways—in wholeness.

The child belongs to life; is subject to law (of life); functions as a whole; the child is unique; growth is self-activity:

These are the paragraph headings in Part I which will lead the thinking teacher, the alert supervisor, or the wide-awake public health nurse to read with deepening interest.

These paragraphs and the pages on fostering child growth will cause us to check more critically our own understanding of child growth and our relationships with him as a growing human

being. Within these pages, simply expressed, is a viewpoint toward which progressive thought in education is moving today! The whole child in terms of his span of life from conception to maturity; the whole child as a growing and functioning organism; the whole child in his social relationship.

Under this point of view the author contemplates that health cannot be taught in the home, school, or community, as a separate subject, but grows out of and becomes a part of all daily living and learning within the pupils' own experiences.

But alas, Parts II and III, like so many of our so-called progressive schools, fail so often to carry out this point of view in its suggestions for actual living and wholesome learning experiences on the part of the child.

Parts II and III of the book are devoted to emphasis—"things pupils should know or experience" on a grade level or year-by-year basis. This certainly is not in harmony with the point of view advocated in Part I, for experiences and knowledge cannot be so formally classified. Each of these items is carefully numbered to lead the teacher to a host of artificial methods and devices under the title, *The Curriculum—Specific Phases*. Many of the references for pupils and teachers listed under the bibliography in the appendix are filled with the devices—health plays, height-weight tables, and rewards which—we believe rightfully—the author of this book indicates elsewhere in the text as extraneous, artificial, useless, and unhygienic. Revised editions of many references are not indicated.

There are many helpful suggestions within these pages which are in harmony with the principles of child growth set up in the introductory pages, but the teacher will have to use her own judgment to select the activities which meet these needs. Will the public health nurse find this book helpful? Yes. For the

nurse who is searching for a better understanding of the newer education and the basic principles of child growth, the first 57 pages hold an excellent point of view. The section of the supplement under *Estimate of Wholeness* presents a challenge to reflective thinking. The one-sided factual information on tobacco, alcohol, and narcotics and the point of view on sex education in the elementary grades may be helpful.

Can the nurse recommend this book to teachers? Yes, after the nurse herself has read it, and can see at least some basic reasons for suggesting to the teacher that she take a questioning attitude toward some of the suggested pupil activities. Classroom teachers will find Part I and the briefly excerpted factual material in Part III most helpful.

REBA F. HARRIS
Louisville, Kentucky

REAL LIVING

Real Living—A Health Workbook for Boys in Junior High Schools. By Ross L. Allen, Dr.P.H. 106 pp. A. S. Barnes and Company, New York, 1939. 50 cents.

Real Living—A Health Workbook for Boys in Senior High Schools. By Ross L. Allen, Dr.P.H. 68 pp. A. S. Barnes and Company, New York, 1939. 50 cents.

In the first of these two books, which is for young boys, 21 aspects of individual health are presented in a concise, usable form for adolescent study. Each section is treated in the same orderly manner, with introduction, references for the student, questions to be answered in essay form, and suggested activities. The problems presented cover a wide range of subjects including the developing of a scientific attitude toward health, various health practices, accident prevention, and first aid.

The approach to each section is interest-provoking, but there is lack of continuity throughout the book. There is no illustrative material, which is essential to a workbook.

In the book for senior high schools, the author has emphasized information

which will help young men to take part in community health organization, and has presented new problems with which they will be confronted. Some of these are causes of communicable diseases, the routes of infection, appendicitis, preparation for marriage, mental hygiene, industrial hygiene, traffic and highway safety, alcohol, and tobacco.

No doubt books of this type will prove valuable to teachers who want to help a particular group of students learn to use reference material. However, it is important to remember that health education is not confined to fact-finding. After all, one of the prime necessities in health teaching is to help students solve their own problems and to adopt desirable health practices.

NORMA P. LEITCH
Newark, New Jersey

CHILD NUTRITION IN CAMP AND INSTITUTION

By Victoria Kloss Ball. 301 pp. The Welfare Federation of Cleveland, 1938. \$1.50.

The material in this publication is the result of a study of food costs, dietary contents, and food administration in 15 camps and 18 institutions affiliated with The Welfare Federation of Cleveland. Suggestions for planning food budgets, balanced diets, menus, recipes, kitchen organization, camp cook-outs, and many other topics are included.

Material in the tables of food costs is based on U. S. Department of Agriculture Bulletin 1757. Tables of ideal nutritional standards are based on accepted standards. A complete bibliography is included.

Dietitians in camps and institutions should find this book useful. Camp nurses—especially those with a limited background in dietetics—who are responsible for camp nutrition programs should find it a veritable Baedeker for guidance in planning and executing a satisfactory nutrition program for campers and camp staffs.

LULU ST. CLAIR BLAINE, R.N.
Detroit, Michigan

DISEASES OF THE FOOT

By Emil D. W. Hauser, M.D. 472 pp. W. B. Saunders Company, Philadelphia, 1939. \$6.

This comprehensive book provides a basis for understanding the normal and abnormal foot and gives a detailed account of the treatment of all foot disorders.

Although it is written primarily for physicians, all nurses will profit greatly by a careful study of the first four and the ninth chapters. These deal with the anatomy and physiology of the foot, examination of the foot, hygiene and general care of the feet, and postural disturbances and their relation to the foot. The practical suggestions on choice of shoes and training in walking and standing are especially helpful. Other chapters are valuable for reference, particularly for nurses working in orthopedic programs.

Well chosen illustrations and directness and simplicity of style add to the effectiveness of presentation of a subject which is of great interest to nurses.

J. L. S.

MAN AND HIS HEALTH

Man and His Health, a description with illustrations of the medical and public health exhibits at the New York World's Fair in 1939, is available from the American Museum of Health, Room 924, 30 Rockefeller Plaza, New York, N.Y. The price is 25 cents.

ALCOHOL

Its Action on the Human Organism

By a Committee originally appointed by the Central Control Board (Liquor Traffic) and later reconstituted by the Medical Research Council. 176 pp. His Majesty's Stationery Office, London, England, 1938. Obtainable from British Library of Information, 50 Rockefeller Plaza, New York. 30 cents.

This revision of the book presents the research and findings of a committee appointed by the Central Control Board (Liquor Traffic) and later reconstituted by the Medical Research Council of England to answer the question: What

is known concerning the action of alcohol on the human body? It is devoted entirely to a discussion of the action and effects on the body, and does not attempt the interpretation of the broader social and emotional implications of the effects

of alcohol on man. However, the content is in line with the stated purpose of the book. It will be of value to individuals and groups who want authoritative information on the effects of alcohol on the human body. A. C. G.

RECENT PUBLICATIONS AND CURRENT PERIODICALS

GENERAL

ACCIDENT FACTS. National Safety Council, 20 North Wacker Drive, Chicago, 1939. 104 pp. 50c. for single copies, lower prices for quantity orders.

The 1939 edition of *Accident Facts* is beautifully illustrated with graphs and charts, and carefully indexed. This pamphlet summarizes accidents of the year under eight headings: all accidents, occupational, motor vehicles, other public, railroad, aviation, school, and home.

I LIKE OLD FOLKS. William H. Matthews. *The Survey*, April 1939, p. 101.

"One of the reasons for my fondness for work with old people is that I do not have to worry about being constructive," says the author in this provocative article on the care of the aged. Every nurse will find it helpful in her approach.

THE ETIOLOGY OF MALIGNANT TUMORS. Carington Williams, M.D. *The Bulletin*, American Society for the Control of Cancer, 1250 Sixth Avenue, New York, December 1938, p. 2.

An excellent summary of our present knowledge regarding the causes of cancer.

LEST WE REGRET. Travelers Insurance Company, Hartford, Conn., 1939. 36 pp. Free.

Offers authentic facts about automobile accidents in which 32,000 persons were killed and more than a million injured in 1938. It contains information of a graphic and pictorial nature which would be helpful in presenting material for a safety talk.

INTRODUCTION TO MATERIA MEDICA—DRUGS AND SOLUTIONS. Stella Goostray. The Macmillan Company, New York, 1939. 184 pp. \$1.75.

EYE, EAR, NOSE, AND THROAT MANUAL FOR NURSES. Roy M. Parkinson, M.D. C. V. Mosby Company, St. Louis, fourth edition, 1939. 243 pp. \$2.25.

MICROBIOLOGY APPLIED TO NURSING. Jean Broadhurst, Ph.D., and Leila I. Given. J. B. Lippincott Company, Philadelphia, fourth edition, 1939. 653 pp. \$3.

THE SUPPORT OF LOCAL GOVERNMENT ACTI-

TIES. Committee on Local Government Activities and Revenues. Municipal Finance Officers Association, Chicago, 1939. 75 pp. 50c.

DISTRICT HEALTH DEVELOPMENT, DEPARTMENT OF HEALTH, CITY OF NEW YORK. Department of Health, City of New York, 1939, 53 pp. \$1.

A brochure giving the history of the district health centers in New York City and the plans for future development. It contains photographs and floor plans of the health center buildings.

HISTORICAL DIRECTORY OF STATE HEALTH DEPARTMENTS IN THE UNITED STATES. Robert G. Paterson, Ph.D. Ohio Public Health Association, Columbus, O., 1939. 67 pp. \$1.

MENSTRUAL DISORDERS. C. Frederic Fluhmann, M.D. W. B. Saunders Company, Philadelphia, 1939. 329 pp. \$5.

Although written primarily for physicians, it is expressed in simple language and should be a good reference book for up-to-date information concerning the menstrual cycle and newer medications used in the treatment of various disorders of this cycle.

ORGANIZED PUBLIC NURSING AND VARIATIONS OF FIELD PROGRAMS IN 94 SELECTED COUNTIES. Joseph W. Mountin, M.D., and Evelyn Flook. *Public Health Reports*, May 19, 1939, p. 815. Superintendent of Documents, Washington, D.C.

MENTAL HYGIENE

NORMALITY AND MATURITY. Maurice Levine, M.D. *The Family*, March 1940, p. 18.

The writer presents a general definition of normality and discusses ten criteria of emotional maturity, which is one of the factors in normality. He calls attention to the fact that there is no attempt in current psychiatric and psychoanalytic thinking to place normal, mature human beings into a separate group. The concept is that normality and maturity are never complete but are only relative varying approximations. This article is practical and timely, and should be helpful to teachers, nurses, executives, parents, social workers, and all so-called normal adults.

NEWS NOTES

- The New York University Center for Safety Education announces 20 fellowships and 40 scholarships in safety education for the academic year 1940-1941. Applications must be received by May 25, 1940. Tuition scholarships for an intensive two-weeks' credit course in that field are also available for the summer of 1940. For application blanks address Dr. Herbert J. Stack, director, Center for Safety Education, New York University, 20 Washington Square North, New York, N. Y.

- Over a million dollars has been contributed and administered for War Relief through the American Red Cross since the beginning of the European war. At the outbreak of hostilities on September 1, 1939, the Red Cross, in fulfillment of its charter and treaty obligations, cabled the International Red Cross at Geneva inquiring as to the possible needs of the Red Cross societies of the belligerent nations.

In October, an American Red Cross delegation of three men was sent to Europe to make a survey of the needs. On the basis of their report, and the reports from the various Red Cross societies and from the League of Red Cross Societies in Geneva, the American Red Cross has sent relief supplies, or money for their purchase in Europe. As of March 30, 1940, the total expenditures and commitments amounted to \$1,185,481. This includes \$330,273 for Finnish War Relief and \$401,107 for Polish War Relief.

It is significant of the speed of the American Red Cross relief operations that within five days after the beginning of the war in Finland the first consignment of medical supplies reached Finland by plane. Later in December two specialists in typhus fever and other Oriental diseases were assigned to the

American Red Cross by the U. S. Public Health Service and sent to Finland at the request of the Finnish Red Cross.

In addition to these expenditures, large quantities of clothing, surgical dressings, and other hospital supplies have been produced by the Red Cross chapters and shipped abroad.

- The annual conference of health officers and public health nurses of New York State Department of Health will be held at Grand Union Hotel, Saratoga Springs, June 25-27.

- The New Mexico State Nurses' Association will hold its nineteenth annual meeting at the La Fonda Hotel, Santa Fe, May 29-June 1.

- Following the death of Malinde Havey, national director of the Public Health Nursing Service of the American Red Cross, many of her friends expressed the desire to perpetuate her memory in some way which would be a living expression of her largeness of heart and her rare gift of friendship.

The National Committee on Red Cross Nursing Service has undertaken to create a Malinde Havey Memorial in order that her friends may honor her memory in a tangible and permanent fashion. This memorial is to take the form of a fund to be held and administered by the Red Cross for the specific purpose of helping national and chapter nurses in active service to meet unusual financial obligations such as those incurred in illness or in further study. For the most part this help will be in the form of loans without interest. Contributions may be sent to the treasurer of the fund, DeWitt Smith, American Red Cross, Washington, D.C. Checks are to be made payable to the Malinde Havey Memorial.

Our Readers Say . . .

THIS COLUMN is intended to serve as a forum for the expression of reader opinion. Only signed letters will be published, although the signature will not be used except with the writer's permission. The National Organization for Public Health Nursing is not responsible for opinions expressed on this page.

THE HORSE-AND-BUGGY ERA

Your foreword in the February issue went right to the heart of the sentimentalist in me. Some years ago I helped to wind up the affairs of a private agency which was merging with an official one. In going over old records and papers, I came across several items like the enclosed one relating to the transportation of their first public health nurse:

June 13, 1917

Joseph Huber
board of horse

May 1st to June 1st
\$30.00

When I looked at our trim little Ford, I realized that it must have been preceded by a horse-and-buggy era in public health nursing. Incidentally our organization thrived for a good quarter of a century under the charmingly simple name of Mamaroneck Society for Lending Comforts to the Sick, Inc.

I have several of these items in my scrap-book showing variations in price as well as the various accouterments needed to keep a horse in good trim. He has a definite place in our historical progress.

HELENA PLATKIN
*Staff Nurse, Department
of Health, New York, New York*

EXCHANGE OF NURSES

I am interested in the possibility of exchanging staff nurses. Is this ever done? If so, where and how? One of the nurses on this staff has been here nine years. She is an attractive, conscientious worker. She does not wish to leave the position, but would be very much helped and inspired if she could work on some large city service for a few months, particularly if coincident with a time when she could take an evening class at college. Our staff might benefit by a worker from a big city service and she might be interested and helped by working in a smaller town. We have bedside and health work, nurses' and medical conferences; and we assist with the city dispensary.

I will be interested to hear of any possibilities along this line.

J. P. EGBERT
*Director, Visiting Nurse Association,
Burlington, Vermont*

EDITOR'S NOTE: A plan for the exchange of nurses recently initiated by the Henry Street Visiting Nurse Service, New York City, is described on page 317. We should welcome letters telling of other experiments in exchanging nurses.

BOARD USES MAGAZINE

You might like to know that the nursing board furnishes PUBLIC HEALTH NURSING magazine to each chairman of four subadvisory groups in the county. These magazines are passed on to the forty-four committee women in Martin County.

Any articles relative to committee member activities will be appreciated.

MABEL WAITE
*Secretary, Martin County Public Health
Nursing Service, Fairmont, Minnesota*

NEGRO HOSPITAL USES MAGAZINE

The journal is always a welcome guest, even though we are institutional workers. It is very inspiring to know what our sister nurses are braving and accomplishing.

MRS. M. H. BRIGHT
*Superintendent, Houston Negro
Hospital, Houston, Texas*

MAGAZINE HELPFUL TO COURSE DIRECTOR

I would like to tell you how very helpful and timely the articles published in PUBLIC HEALTH NURSING the past month have been, particularly those on the merit system, citizen committees, relationships, the home visit, and supervision of school nursing.

A. LOUISE KINNEY
*Director, Division of Public Health
Nursing, St. Louis University,
St. Louis, Missouri*

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UNIFORMS



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 "SEERSUCKER"
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 real comfort.

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PUBLIC HEALTH NURSING

Official Organ of the National Organization for Public Health Nursing, Inc.

Safe at Home!

THERE ARE some 30,000 fatal accidents which occur each year in the home—nearly as many as are attributable to the automobile," said Dr. C.-E. A. Winslow in an address on "Housing and Health" at the N.O.P.H.N. Biennial Convention dinner in Philadelphia on May 15. "Can it be doubted that rickety steps and rotten handrails, dark stairways, wood stoves, and kerosene lamps contribute to a substantial portion of these fatalities?" Thus in a sentence Dr. Winslow linked two problems on which the spotlight of attention is directed today—home safety and housing.

Of course, many other factors besides poor housing enter into home accidents. Human carelessness and thoughtlessness are significant causes, as Deborah Bacon points out in her forceful article (page 363) in which she urges the public health nurse to sharpen her powers of observation and use her resourcefulness to help families see potential causes of accidents and take preventive measures to save lives and limbs. Even in new housing projects, problems are presented in the safe use of mechanical devices to which the tenant is unaccustomed, and safety education of a specific kind is already planned for these homes. It requires no statistics to show, however, that the hazards in an old law tenement or a rickety shack are enormously greater than those in a well built, well lighted, safely heated house.

Yes, housing and safety in the home are closely related problems. The National Organization for Public Health

Nursing has already taken steps to keep its members in touch with developments in regard to both. The Board of Directors at its January meeting authorized the appointment of a Committee on Housing and a Committee on the Nurse's Part in Safety. Both committees will be appointed for the next biennial period.

The Committee on Housing will keep in close touch with the work of the United States Housing Authority and with the projects and activities for better housing in various states. The Committee on the Nurse's Part in Safety will concern itself with the prevention of all accidents—home and otherwise—which as Miss Bacon points out are the highest cause of deaths in the age-group from five to twenty. This committee will work in close coordination with all agencies interested in safety. The National Safety Council is of course the organization primarily concerned with the problem of accident prevention. Many others are, however, vitally interested. The Metropolitan Life Insurance Company has a continuous safety educational program and it presented an exhibit emphasizing the nurse's part in home safety at the Biennial Convention in Philadelphia in May.

Both committees will concern themselves especially with the way in which the public health nurse can participate in the solution of the problems of housing and safety, and will endeavor to keep nurses informed on the latest information in both fields.

NOTE: Dr. C.-E. A. Winslow's paper will appear in the July issue.

The July number will be the special Biennial Convention issue.

Effects of Medical Advances on Nursing

By IAGO GALDSTON, M.D.

Recent advances in medicine and the development of personal preventive medicine imply changes in the functions of the public health nurse

IF WE INQUIRE what advances have taken place in medicine during the past quarter of a century, an enormous number of items come to mind at once. But as we begin to define these items, the suspicion dawns upon us that in recounting them one by one we are likely to become bogged in miscellany. In order to summate the recent advances we must rise above the single item. From such a vantage point we can perceive the direction and momentum of progress.

THE ERA OF BACTERIOLOGY

Let us begin then by visualizing the position of medicine in 1914. At this time Pasteurian medicine was at its zenith. The trend of thought engendered by the achievements of Pasteur, Koch, von Behring, and Virchow, prevailed throughout—in pathology, clinical medicine, and public health. This was what may be properly called the bacteriological school of thought—and the era during which it prevailed, the bacteriological era. Bacteria and their toxins monopolized attention, and the resources and energies of the practicing physician as well as those of the public health worker were consumed in waging a sustained war on the pathogenic organisms. This was the time of elaborate fumigation and disinfection, of ritualistic quarantine, and of multiform vaccines. This was the period during which such catch phrases as "A clean tooth never decays" went unchallenged and were accepted as a self-evident verity.

Of this period Arnold C. Klebs, writing in 1917,¹ said:

Since we have become acquainted with microorganisms and their role in diseases, aetologic research, because of its tangible object, has exerted a determining influence on medicine. It has gone almost to the extreme of making aetiology and bacteriology synonymous terms So dominant is this doctrine that the question is hardly ever asked; might there not be, apart from the microbe pathogenic influences of equal if not of greater importance?¹

The thought that there were other pathogenic influences apart from microbes did not arise spontaneously, but was engendered by cumulative experience. In the early years of this century, it dawned upon a number of scientists that bacteriology, immunology, and cellular pathology did not encompass all there is to disease. The more critical students realized that the state of the body must perforce contribute engendering factors to the episode, disease.

THE SEED AND THE SOIL

The dominance of Pasteurian medicine was at this time challenged by newer concepts, among which the earliest and most significant were that of the seed and the soil. No one person can be credited with the crystallization of this idea, though in this connection one must recall Trudeau's simple and beautiful experiment in which he subjected two lots of rabbits infected with tuberculosis, one to the best possible, the other to the worst possible environmental conditions. Trudeau drew the conclusion that "the course of the disease was greatly influenced by a favorable or un-

favorable environment."² This was in 1885.

The idea that the condition of the body is a determining factor in bacterial disease was in the first decades of the twentieth century a revolutionary one. Its enunciation marked a great advance in medical thought. However, when the question was asked, what factors can render the soil nonreceptive to the seed? the answers given were rather vague. They were expressed in such generalities as cleanliness, good food, rest, and exercise. The categories were there but the essential details were lacking. The fact is: the specific answer was unknown. At that time, the medical sciences, anatomy, physiology, and pathology were in content and viewpoint necrological rather than biological. They were largely based on what studies of the dead body, dead tissues, and isolated organs revealed.

OTHER CAUSES OF DISEASE

In the second decade of the present century there were certain stirrings of disaffection noticeable in the scientific realm; gropings if you please; symptoms that all was not well with medical theory and practice. Certain special lines of study were clamoring for attention—for example, endocrinology, nutritional physiology, and psychiatry. These studies were tangential to bacteriology. Pasteurian medicine did not embrace them, indeed had no brackets for them in its elaborate schemata of morbid forces. These studies pointed to the existence of pathogenic influences other than—and possibly of greater importance than—the microbes.

A few dates will help us orient our thoughts.

VITAMINS DEMONSTRATED

In 1906 we find the celebrated Wisconsin experiments. These experiments, performed with cattle, proved that good nutrition involves more than adequate

caloric intake and a balanced ratio of proteins, fats, and carbohydrates. In 1906 F. Gowland Hopkins of England in an address entitled "The Analyst and the Medical Man" forecast the discovery of the vitamins.³

In 1911 Osborne and Mendel published their classical monograph, "Feeding Experiments with Isolated Substances."⁴ A year later Hopkins published his monumental studies clearly demonstrating the existence of what he called accessory food factors.⁵ In the same year, 1912, Casimir Funk, working at the Lister Institute of London, coined the term *vitamin*. In 1913, Osborne and Mendel reported the development of the eye disease xerophthalmia, in the animals maintained on a Vitamin A deficient diet.

From this brief schedule of dates we gather that by 1914 the existence of the vitamins had been clearly visualized and demonstrated. Furthermore, it had been shown that vitamin deficiency hampered growth and development, and in at least one instance engendered disease.

ADVANCES IN ENDOCRINOLOGY

Scanning the dates of endocrinology we find that before 1914 but two hormones had been isolated, while since then more than 30 have been identified. In 1914, Kendall succeeded in isolating thyroxin, the active principal of the thyroid gland.⁶ In 1921 MacLeod, Banting, and Best discovered insulin. In 1923 Allen and Doisy isolated the estrogenic hormone.⁷

IMPETUS TO PSYCHIATRY

Psychiatry affords us fewer crucial dates. However, we may note the launching of the mental hygiene movement by Clifford Beers in 1909; Freud's visit to the United States in 1909, which enormously stimulated interest in psychoanalysis; and the appointment of Thomas W. Salmon in 1915 as medical director of the National Committee for

Mental Hygiene. The first World War gave an enormous impetus to psychiatry and to mental hygiene. During the last 25 years, the great labors of Freud and of Adolf Meyer have implemented psychiatry and mental hygiene, and have infiltrated medical thought and practice.

So much for chronology. Now let us sum up these advances.

IMPLICATIONS OF NEWER KNOWLEDGE

We have taken note of the fact that at the beginning of the twentieth century there developed a dynamic appreciation of the soil factor in disease. This appreciation was developed not so much by the reasoning of astute clinicians as by the growth of our knowledge of the vitamins and nutrition, of endocrinology, and of psychiatry. The new knowledge gave us added competence in the treatment of disease.

Vastly more important, however, is the profound alteration in our understanding of the nature of disease and the full potentialities of the state of health. Thus, in the light of what endocrinology has taught us, we may no longer conceive of disease as affecting an organ in an individual's body, the rest of which is sound or only embarrassed by the deficiency due to the diseased organ. We must, on the contrary, conceive of the organism as a whole and the affected organ as an article in the speech of disease.

In our recently acquired knowledge of nutrition and the vitamins, we have clear evidence of the determining influence which environment in its broadest sense has upon the incidence and gravity of disease and upon health. Our newer knowledge has forcefully impressed upon us the need to anticipate and the possibility to forestall disease by the proper cultivation of the soil—by favoring the normal development of the body and by maintaining and improving its resistance not alone against particular germs and

toxins, but against practically all the morbid forces which surround the individual.

Among the morbid forces we have learned to assign great importance to the psychobiological ones. In safeguarding and promoting the health of the individual, mental hygiene is being recognized as on a par with the hygiene of nutrition and of bacterial cleanliness.

To summarize, the great advances in medicine which have taken place in the last three decades are best witnessed not in the newer diagnostic procedures, not in the finer and more effective therapeutic instrumentalities, fine as these are, but rather in the expansion of our understanding of the origins of disease, and in the growth of knowledge, as well as in the eagerness to apply that knowledge to the anticipation and prevention of disease, and to the promotion of optimal well-being.

Thus far our appraising eyes have swept the wide fields of medicine. Now it is pertinent that we should focus them upon the more restricted terrain of public health. For if we are to point our consideration to the operations of the public health nurse it must be by way of a transitional consideration of public health.

PUBLIC HEALTH A SOCIAL MOVEMENT

The belief is common that public health or preventive medicine sprang from the modern science of bacteriology. It is true, of course, that bacteriology implemented public health, that it endowed it with the knowledge and techniques essential to the achievement of its immediate objectives. But it is equally true that even before the time that bacteriology developed into a practical science, the basic principles of public health and the social philosophy upon which they rest had already been well established.

In its origin, modern preventive medicine was in no small measure a move-

ment of reaction against the brutal and degrading conditions under which a large portion of mankind was compelled to exist.

The public health movement drew its charter principles from the humanists and the social philosophers of the late eighteenth and early nineteenth centuries. These were the reformers who agitated against the corruptions in civil, political, and economic life that came in the wake of the Industrial Revolution. Public health was but one aspect of the movement for reform. It was linked to the campaigns against the exploitation of labor, against intemperance, illiteracy, and slavery. It envisaged reform in government and in the very philosophy of the responsibility of the state for the health of the people.

In its earlier stages the public health movement was steeped in the philosophy of social amelioration, expressed in the Benthamite formula "the greatest happiness of the greatest number." Its objectives were better living conditions, better working conditions, and shorter hours of labor. It saw in these the means for preventing disease, improving health, and prolonging life. It strove to improve the *total* environment of the *entire* population, and particularly that of the underprivileged portion. To that end we find the pioneer public health workers concerned themselves with water supplies, sewage, garbage disposal, nuisance abatement, factory inspection, child labor, working hours, and wages.

HEALTH OBJECTIVES CHANGED

Toward the end of the last century bacteriology gained dominance in the field of public health and with that domination came a profound change in the temper and objectives of the movement. It lost its reformist nature. Instead of striving for general amelioration of working and living conditions, it centered its energies on "stamping out" specific diseases. It waged war on small-

pox, on typhoid fever, on cholera, on tuberculosis, on diphtheria. The newer public health workers inspected water, milk, and foods; established the modern type of quarantine; did mass inoculations; practiced fumigation and disinfection; and developed the science of epidemiology.

Whereas, therefore, the public health movement at its inception aimed to strike at the roots of the evil, it later turned its energies against such particular manifestations of the evil as it felt competent to tackle. Judged by the results, this change in tactics was most fruitful. And yet, the public health movement lost much when it abandoned the broader humanism of its pioneers, when it discarded the ideal objective—that of the amelioration of the total environment. Modern public health much like modern medicine has been too much preoccupied with bacteria and with morbid processes, and too little with the other environmental factors that so vitally affect health.

ECONOMIC FACTORS OF HEALTH

The economic factors of health, so keenly appreciated by the pioneers in public health, for long have been overlooked, underestimated, or dismissed as being outside the realm of public health. This separation of economic factors from the others that influence well-being is glaringly noticeable in much of the disputation that goes on concerning the so-called socialization of medicine. It is argued that more and better medical service would gain for the people superior health which, of course, is partially true. But too little critical consideration is given to the other factors that favor health, and of which there is a more widespread and greater need; namely, more and better food, better housing conditions, creative work, opportunities for wholesome recreation, and economic security. These observations are not intended to be critical of the

modern public health workers. They are intended to depict the radical change which the public health movement has undergone, and to point out a serious deficiency in its present-day philosophy.

RECOGNITION OF SOCIAL ASPECTS

Candor requires acknowledgment of the renewed interest in these matters among the workers in the public health field. We now frequently hear such telling observations as the following: "Studies have invariably shown that wherever economic status is low, infant mortality is high." "Fifty million Americans are in families receiving less than \$1000 income a year. Illness and death increase their toll as income goes down; medical care decreases sharply as need for it mounts."

There is, in fact, something of a return to the viewpoint of the pioneers in public health; the recognition that the total environment of the individual needs to be bettered if his health and well-being are to be served.

One must be grateful that there is at last a frank acknowledgment of the determining role which adverse economic conditions have in the engenderment of disease. In due time it may be hoped a deeper insight will be gained into the relationship of poverty to disease, and that to poverty—so largely the product of our economic maladjustment—will be charged in full the morbidity for which it is responsible.

PUBLIC HEALTH A BROAD CONCEPT

The terms *public health* and *preventive medicine* are commonly used as if they were identical in meaning and interchangeable, and yet they do not mean quite the same thing. Public health is the broader, more inclusive field. Preventive medicine is a subsidiary part of public health. Public health is what the pioneers aimed at; preventive medicine is what their followers practice. It is to preventive medi-

cine that we owe our comparative freedom from the communicable diseases that plagued the past generations.

The great achievements of preventive medicine were largely the results of environmental sanitation. Neither the individual members of the community nor its physicians had much active part in the improvement of the water supply or in the safeguarding of the milk supply. Once legislative authorization and the required funds were obtained, the improvements could be effected through the efforts of a comparatively small group of paid executives and staff workers. It was thus, indeed, that great plagues were conquered.

However, not all diseases can be mastered in this manner. The intelligent coöperation of the individual members of the community and of the medical profession is required in order to make headway against an appreciable number of important diseases.

The last two decades have witnessed the development of what, in contradistinction to communal preventive medicine, may be called personal preventive medicine. The distinction between the two may be summed up in the statement that while an individual can be protected against certain diseases through the efforts of other human beings, there are some diseases against which he can protect himself only by his own efforts. However, personal preventive medicine is not restricted to the prevention of disease. It is even more vitally and actively concerned with the optimal development of the individual and with the retardation of morbid and degenerative processes.

Personal preventive medicine is still in the formative, developmental state. It cannot be said that it looms large in the everyday practice of the average practitioner. It cannot even be claimed that the medical profession, or the public, are aware of its great potentialities. Only a small number among the leaders

in medicine and in public health are adequately aroused to its great promise.

Much of the recent development in medicine points in the direction of a wider practice of personal preventive medicine. Thus, what we have learned and are applying in nutrition is of immediate service in the treatment of nutritional disorders. But this knowledge, applied in the nutrition of well persons, is of infinitely greater value in the prevention of a vast variety of disorders. Modern psychiatry has not only revolutionized the treatment of the mentally sick; it has also given rise to the mental hygiene movement which, though still groping for a charter of objectives and the definition of its basic techniques, has already rendered immensely valuable service in its preventive clinics. Endocrinology still remains a terrain to be explored, but even in this field personal preventive medicine already finds application.

These most desirable developments we can credit to the increasing knowledge of the physiology of the animal body. Knowing better how the body operates and its requirements, we can better serve it. However, our present-day physiology is not to be confused with the dissecting table and test tube physiology of the last century. It is a radically different science, involving a different mental discipline.

Present-day physiology is essentially biochemical. It studies the living rather than the dead organism. It is dynamic rather than static, functional rather than structural. Modern physiology is as mindful of the psychological phases of the living body as it is of the basic chemical elements that compose its substance. It subscribes to the profound verity that the whole is greater than the sum of its parts. It realizes that qualities not apparent in disjointed elements may be engendered by the union of those elements.

The future belongs to preventive medi-

cine and more so to personal than to communal preventive medicine. It is not likely that curative medicine will ever fall into disuse. Man is too perverse a creature not to require periodic mending. But there is little doubt that by the application of the ever growing knowledge on the optimal care of the human body, many disorders and diseases which are widely prevalent today will disappear spontaneously.

The last fifty years have witnessed the beginning of this trend. Diseases such as chlorosis (an anemia disorder common formerly among young women) nephritis, tuberculosis, pneumonia, whooping cough, and scarlet fever have declined markedly even though until very recently we had no specific means for combating any of them. Even those diseases which are presumably on the increase are suspected to be exacting a relatively lesser toll than they did in former years.

EFFECT ON FUNCTIONS OF NURSE

We must now ask: What effects are the changes that have taken place in medicine and in public health likely to have on the functions of the public health nurse?

CARE OF THE SICK

As to the immediate future, this, it seems to me, needs affirmation: The primary function of the public health nurse is bound to remain ministrations to the sick. *Semper consolare et juvare* must be the signature of her service. Her basic education and the tradition in which she is steeped should fit her for and dedicate her to this devotion. Despite the phenomenal developments in the field of therapeutics, it is improbable that there will ever be a dearth of persons requiring the ministering care of the physician and the public health nurse. The type of service required will no doubt change, but the need for service, far from declining, is likely to grow. This considera-

tion dictates the injunction that every public health nurse should be thoroughly grounded in the elementary rudiments of nursing principles and practices. Such preparation will allow and facilitate the adaptation of functions to changing needs. Such preparation will permit subsequent specialization in service without hazarding the usefulness of the nurse should the need for the specialty service decline.

It is too early to venture a guess as to what effect the newly developed therapeutic instruments are likely to have on the general morbidity of the people. Their effects on the mortality are being reflected in statistics. We know that the chemotherapeutic agents, the specific prophylactic agents, and the immune sera are reducing the incidence and the death rates of a number of diseases, as well as appreciably shortening illness duration and reducing the incidence of complications. All of this appears to imply a reduction in the need for nursing. But there are certain remote effects to be considered.

The person who is cured of his pneumonia by serum or sulfapyridine does not live "happy and healthy" forever thereafter. He is rather spared to ail another day of another illness. The high development of the science and practice of pediatrics has necessitated and made possible the practice of geriatrics. Moreover, there are many fields wherein the services of the public health nurse are sorely needed but little applied—for example, the fields of convalescent care and of geriatrics, the nursing care of the chronically ill, psychiatry and mental hygiene. By listing these as the uncultivated fields it is not implied that those in which the public health nurse is now active have been fully cultivated. On the contrary, there is probably no sphere wherein the saturation point of public health nursing care has been reached.

Thus far attention has been directed

to nursing service to sick persons. This is cardinal to but not the all embracing function of the public health nurse. There are two additional services named among her principal duties: the prevention of disease and the promotion of health. The great future of public health nursing lies in the contributions it can make to these fields.

Miss Adelaide Nutting has well said: "Medical science has as yet found no better way to speak than through the voice and the personal ministrations of the visiting nurse, no more strategic point of attack than the homes in which she works"¹⁸

To this we may add that never before has medicine had so many telling facts to impart, so much solid instruction to offer on the prevention of disease and the promotion of health. These are now more than pious wishes; they are attainable objectives.

It is incumbent on the leaders in the public health nursing field to make certain that the "voice of the visiting nurse" is competent and informed. Upon the public health nurse will be placed responsibility for teaching personal preventive medicine. However, it must be appreciated that little if anything in the basic preparation of the nurse serves to equip her for such service. Additional knowledge and training are required.

The facts basic to personal preventive medicine are not exclusively drawn from the sick room or the autopsy table. They largely come from the biochemists' laboratory, from the unattached research center, from the isolated experimental station. The practice of communal preventive medicine, remote as it was from the practices of clinical medicine, was yet more akin to it than is the practice of personal preventive medicine. The basic preparation of the public health nurse must, therefore, be supplemented with organized instruction in the matter, objectives, and techniques of personal preventive medicine. This training is

to be given to every public health nurse, and not merely to the specialist nurses. Such training should be formulated by a joint group comprising experts in this phase of public health and leaders of public health nurses. It is to be administered under the supervisory care of the appropriate public health nursing organizations.

The public health nursing profession has been for long ancillary to medicine and public health. It is time that it assume a primary status. The profession should and can be more than a voice in the service of medical science. It can

and should also be an intelligence contributing to and affecting what it voices to the public. The profession should charge itself with the responsibility of promoting the application of available knowledge on the prevention of disease and the promotion of health, in the application of what I have termed personal preventive medicine. This appears to be the core of the changes in public health nursing functions implied in the recent advances in medicine.

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Improving Our Interviews

By ALICE I. BRYAN, Ph.D.

Helpful suggestions for analyzing our interviews in the light of basic principles are found in this discussion of the purposes and methods of interviewing

EVERYONE who leads a normal social life has countless opportunities for practice in interviewing. Yet only a few people have really mastered this intricate art to the point where they can consciously achieve objectives often not to be attained successfully by any other method. No amount of practice will bring proficiency in interviewing, unless the practice consists in applying certain principles which insure effective results. The old maxim "practice makes perfect" is very misleading. All that is made "perfect" by practice is the actual performance that is being repeated; inadequacies in that performance, far from being remedied, will merely be fixated and will be more difficult to overcome as practice continues. To improve our interviews, then, we need to examine our practices in the light of basic principles and revise our procedures wherever necessary to bring them into harmony with these principles.

PURPOSES OF INTERVIEWS

In analyzing an interview, the first question might well be: What is the purpose of this interview? While every interview must have a purpose (by definition, an interview is "a conversation with a purpose"), a series of interviews in the course of a morning's work may differ considerably in the purposes for which they are conducted.

One purpose is that of obtaining information not available in any other form. If the desired information consists of facts which are available else-

where, the interview is usually a wasteful method of obtaining them. The fact-finding interview is best used for securing information of a personal or subjective nature, such as items of personal history, opinions, feelings, attitudes, and interpretations. Much skill is necessary to elicit information of this sort, to verify its reliability, and to interpret it objectively. This is especially true when the information is to be used in scientific research; it also applies to information obtained for diagnostic purposes.

Another type of interview is that conducted for the purpose of selling something, whether it be a product, an idea, a person, an organization, or a service. The main task here is to influence or motivate the interviewee, so that he will think or act in a way favorable to the cause of the interviewer. This may or may not be to the advantage of the interviewee, but in order to achieve the purpose it is usually essential to persuade him, either directly or indirectly, that it is advantageous to respond as the interviewer suggests.

Often this type of interview involves the accomplishment of another purpose, that of giving information or instruction, so that the person will know not only *what* to do, but *how* to do it. Thus, a mother may be "sold" the idea that good nutrition is essential for the health of her family and that she can insure it by serving them balanced meals; but this idea may have no outcome unless she is shown how to plan, purchase, and prepare food on a very limited budget, or

even how to obtain the necessary amount of money.

One more purpose for which interviews are useful is that of providing psychological guidance or therapy. This is undertaken when the person needs help in adjusting to some difficulty or in working out a solution to some personal problem. The objectives sought in this type of interview are to give insight into the nature of the problem or difficulty, to analyze possible outcomes of different modes of behavior, to provide facts necessary for constructive action, and to strengthen the personality by building healthy attitudes of self-confidence and responsibility. It will be seen that this task may require a series of interviews, some of which are conducted for purposes mentioned previously, which must be accomplished before therapy can progress.

Whether an interview is designed to serve one or more purposes, the important thing is that the interviewer recognize clearly what his purpose is and shape the conversation throughout toward the accomplishment of that purpose. Otherwise, the interview will lack organization and orientation; as a result the interviewer may fail to accomplish anything of real value and he may even work at cross-purposes with himself, not to mention his client or patient.

To understand beforehand the purpose of an interview, the interviewer should of course know as much as possible about the problem to be discussed and the person with whom the conversation is to be held. Sometimes, however, it may not be possible to know anything. When this is the case, the first part of the interview is utilized to get this information. Perhaps the interviewer and the client together will then decide what the purpose of this particular conversation should be—if more than one purpose seems possible and time is limited. When a series of interviews is undertaken, they should insofar as possible

be planned as a whole beforehand, so that each may constitute a definite step forward in achieving predetermined objectives. At the conclusion of each, the interviewer will make an objective estimate of what has been accomplished and if necessary revise the tentative plan for the interviews to follow.

ESTABLISHING RAPPORT

When the interviewer has familiarized himself with any available information about the person and the problem to be considered, he is ready to meet the interviewee. The next task is to gain rapport. Perhaps the best way to do this is to regard the interview as a social situation. If the interview is held on the "home grounds" of the interviewer, the latter accepts the role of host or hostess. After the guest has been graciously welcomed, he is made just as comfortable as possible, both physically and mentally. Since he is going to discuss personal matters, he is assured of privacy, at least to the extent that no one else is within hearing distance of his voice. Interruptions from outside sources should be completely excluded, whenever possible, for they may prove so distracting to the client that rapport will be broken and not fully restored throughout the remainder of the session. Not only should outside distractions be eliminated, but the interviewer will also guard against injecting any opinions, interpretations, or experiences of his own into the situation. His job is to interview the client—not to give information about himself or indulge in self-expression.

It is important that the interviewer establish himself as soon as possible as a friendly, sympathetic, and entirely sincere person who can be trusted to safeguard the interests of the client. Much can be accomplished by a few minutes of pleasant and natural social conversation. When the client seems relaxed and comfortable, he may then be invited to discuss one of the least personal aspects of the problem at hand. From this

point on, he can be led tactfully into more personal matters.

Throughout the whole period, the interviewer will remain sensitive to any indications that the client may give of embarrassment, insecurity, or hostility, and regard these as symptoms of a need for better rapport. The interviewee should never be made to feel inferior or on the defensive. Questions are adapted to his level of education and intelligence and his statements are received with interest, respect, and courtesy. He should not be hurried, interrupted abruptly, or made to feel that he is wasting the interviewer's time with irrelevancies. It is better to treat digressions gently by indicating tactfully that these matters are interesting and need further discussion, but that it might be better to concentrate first upon the more immediate needs of the client. Sometimes it is helpful to refer to questions or notes that have been jotted down, to bring the client's attention back to essential points. It may also help to further the purpose of the interview if a brief, informal review is made occasionally to show what points have been covered and in what direction further progress can be made.

INFLUENCING ATTITUDES

When the purpose of the interview is to impart information or change attitudes, with a view to changing the subsequent conduct of the client, persuasiveness rather than an authoritarian approach will be found much more effective. The needs, interests, and prejudices of the interviewee must be kept in mind constantly and an attempt made to give him insight and a feeling of security; the interviewer should not appear to be forcing advice or action upon him which he is not ready or willing to accept. Many attitudes which may seem silly and stupid to the interviewer will be found, upon closer analysis, to be serving as defense mechanisms. They

will not be surrendered until the client has received emotional reassurance in the area where the conflict really lies. Resistances of this kind are not easily dissolved and not too much progress can be expected in one interview. When they are encountered, a good relationship should be established and the way left open for further contacts.

When the purpose of the interview seems to have been fulfilled or its termination seems advisable, the interviewer will take the initiative in bringing it to a pleasant conclusion. The client should leave with increased confidence and self-respect, feeling that the interview has been an enjoyable and profitable experience. The door should be left open on both sides for further meetings upon the same friendly basis.

As soon as the client has departed, the interviewer should take time to record in writing, if only briefly, the major trends of the interview. He will indicate what progress was made towards the objectives set up beforehand, what difficulties were encountered, what information emerged that had a bearing on the problem, and what further steps seem necessary. Unless notes are made immediately on these points, memory is very apt to prove inadequate and misleading when the time comes to hold another interview or to make a report on the case.

The interpretation of material obtained through interviews must be made very objectively, to guard against errors of inference. Above all, the interviewer must be careful not to interpret the conversation in terms of his own personal biases, but with scientific accuracy and objectivity.

If the interviewer can then apply this scientific objectivity to evaluating his own success in conducting the interview, making note of anything he intends to do differently next time, he will be practicing interviewing in a way which will be bound to improve his skill.

They "Didn't Think"

By DEBORAH BACON, R.N.

Home accidents represent a public health problem of tremendous importance, and the nurse is the ideal spearhead in an effective program of prevention

THERE is little flaming drama in the individual cases of death or injury in the home. Consequently we have not focused our determined and horrified attention upon this really crying problem.

What is the reason that industry has been able to reduce its accident frequency rate by 68 percent in 12 years? And why has its severity rate been reduced by 45 percent in the same time?¹ Because industry, through its very set-up, could direct an organized effort squarely and steadily at the problem until the desired results were obtained. Why has public health been able to effect its astounding reductions in various scourges in the last few decades? Because the efforts of thousands of individuals have been focused in concerted action on these problems. Large-scale, efficiently organized action, which is one of the finer aspects of American life, is the only way these epidemics and pandemics of life can successfully be attacked.

It is my belief that the public health nurses should take this added burden of home accident prevention upon their shoulders. It is true that their time and ability are taxed already with the amount of work that is expected of them. But I am thinking not so much of them as of the families who badly need assistance and education in keeping their homes and families safe. There is no other group of persons whose work is so widespread geographically and among

all social and economic groups, and who can be so sure of a universal welcome.

There are two qualifications necessary for a subject to be considered a public health problem. First, it must concern large numbers of people. Second, we must be able to do something practical about the problem.

In 1938 there were 8,900,000 non-fatal injuries in the United States, of which 4,650,000 occurred in the home. There were 31,500 deaths from home accidents in this year.² We are all conscious of the terrific toll we exact from ourselves on the highways of America, killing 32,400 in a single year—1938—in automobile accidents.³ Yet, in that same year, 31,500 were killed while they were "safe at home." On the basis of numbers involved, home accident prevention is definitely entitled to a place in the public health program.

Can we do something practical about the problem? Here again we can draw a parallel with highway accidents. We are all conscious of the hazards that "jalopies" constitute upon our highways. We often feel that if we could legislate the wrecks off the roads, much needless death and injury would be avoided. Yet statistics show that only 7 percent of highway accidents can be blamed upon defective mechanism; 93 percent of the blame can be laid to the human factor.⁴ So it is in home accidents. Although we may feel convinced that poverty and bad housing contribute largely to the tremendous

incidence of home accidents, nevertheless the human factor is largely to blame.

Even when the statisticians give "disorder" as a mechanical cause of home accidents, forgetting who made that disorder; even when they decide that "improper use of equipment" is a responsibility that should be placed upon the equipment and not upon the user—we still cannot release humanity from responsibility for over two thirds of the accidents in the home. Neatness, efficiency, carefulness, thoughtfulness, proper techniques, common sense—these are the practical solutions to this problem, which would go far to reduce unnecessary deaths in the home.

Most of us would not believe some of the things that occur in the homes of our neighbors—if not in our own. There is the story of the woman who wished to clean her gloves. Knowing that gasoline is a dangerous tool (one gallon of gasoline equals 85 sticks of dynamite in explosive power) she carefully went out of doors and washed her hands with the gloves on, in a basin of gasoline. Then, feeling that they would not dry quickly enough to suit her, she went into the kitchen and placed her hands, with the still wet gloves on them, *into a lighted oven*. She will never make that mistake again—that, or any other.

Another woman had just moved her family into a new apartment, and in the flurry and exhaustion of unpacking and cooking the first meal there, failed to find her package of flour. In the pantry of this new home, she found an unmarked paper bag full of a white flour and with it baked some biscuits. The next day, one of the children was dead and two others were dangerously ill with arsenic poisoning.

Many a mother has burned her own child to death because she carelessly left a tubful of scalding water in the infant's path. This occurs over and over again, every week in the year. They "didn't think"; they "didn't

know"; they "were in a hurry"; they "have always done it this way."

THE NURSE LEARNS TO OBSERVE

The public health nurse, on her day-by-day visits, can observe hazards in the home as part of her contact with the family. She is in the home, anyhow. Why can she not observe *consciously* all the environmental details that she is seeing with the fringe of her consciousness in spite of herself? But she must know what to see, where to look, how to suggest tactfully, what to suggest practically. The nurse can easily train herself to notice the hazards, the deficiencies, the awkwardnesses in the environment that constitute the raw material of accident. It is surprising how quickly one catches on to the technical details of the methods of preventing accidents, of eliminating hazards. The factual basis for this teaching is simple to acquire, consisting mainly in keenness of observation and a collection of economical, original, simple, and practical gadgets and techniques for better and safer homekeeping. The real difficulty is in the presentation of this material in a psychologically constructive and tactful manner.

The last thing that most women can take without resentment is criticism of their housekeeping, for the American woman's home is her castle. Therefore, the emphasis is always on the new, the better way of doing a specific thing (that one has just happened to hear about) rather than on the evidences of carelessness, laziness, and unintelligent blundering that are so often the fertile medium for growing what we euphemistically term "accidents." The public health nurse is in an excellent position for individual teaching. Her nurse's uniform, her high professional reputation, the possible emotional carry-over of the mother's gratitude for prenatal or child care that proved its

worth to this home—all these things are an invaluable contribution to the client's "readiness to learn." The teaching can be smoothly blended into the normal routine of the home visit. The nurse may know the sad fact that one thousand babies smothered to death last year because of awkwardly placed bed clothes or suffocating down pillows. But her teaching approach to this fact can be deftly inserted into the lesson on bathing the baby, and the mother has acquired all that we wish without any damage to her self esteem.

At the present time one of the most important things in the problem of home accident prevention is for the nurses themselves to see the problem accurately and analytically. We are too apt to observe hastily and in generalities and to confuse the result and the cause.

If Junior has left his roller skates on the stairs and Father comes home tired in the evening and trips over them, falls the entire flight, and fractures a leg, it is not enough to say that the accident was caused by falling down stairs. The broken bone is only the outward and visible sign, the end result of a whole series of events. Like a good newspaper reporter, the nurse must look for the five questions, the *who, what, how, when, and where*, that will strip a situation down to its skeleton. It is true that no amount of analytical observing will put the leg together again, but it probably will prevent the same event from recurring. If the nurse is observant in her contacts, even before accidents occur, she may prevent them from happening at all.

The teaching approach is, of course, that the nurse thought something she saw at Mrs. Jones' home a few days ago was "so clever." Mr. Jones had found an old box for Junior's skates, painted it a bright color, printed Junior's name thereon in large black letters, and placed a lock upon the box. Behold, Junior actually felt some motivation for pick-

ing up his belongings and locking them closely away from all prying persons.

In the field of public health the nurse is dealing with the total individual within his environment. His problem or illness cannot be considered apart from that environment, which is as much a part of himself as is his own shadow. Unless one's suggestions are practical, and above all, economical, they are of no value whatsoever. The nurse who suggests to a tenement dweller that it would be much safer if the halls were better lighted is no different from the doctor who recommends a sea voyage to the patient on relief.

INDUSTRIAL SAFETY IS SIMPLER

How much simpler, comparatively, is the job of the industrial nurse in this field of safety. There, it is only necessary to convince one man or a small group of men that such and such a procedure pays. If one can prove statistically the value of a course of conduct in safety—and it can be so proved, over and over again—a ukase descends and the entire organization conforms. There is only the specific environment and it can be controlled. Many industries—now that they have proved to themselves how well industrial safety pays—are beginning to notice that absenteeism and turnover go on just the same, whether the accident occurs within the area of the plant's responsibility or not. Industry used to think that the employee could fall down whatever stairs he liked, so long as they were not the factory's stairs. But now the idea is getting around that home and highway safety *do* very definitely concern industry when the individual injured in his private capacity becomes a liability in his official capacity.

The private duty nurse can approach this subject in much the same way as the public health nurse. She, however, is perhaps more likely to function in environments where there is better equip-

ment to work with and where the family can manage to acquire some of the things that will make the home more efficient and more safe.

But in the lower-income homes of America, each individual family must itself be convinced of the value of home accident prevention, and they are not at all interested in logical or statistical proofs. A nation giving to buying non-existent lots, plunging on the stock market, and buying Irish sweepstake tickets is constitutionally incapable of figuring out the inevitability of the law of mathematical chance. Nor are they interested in the personal application of impersonal horror stories. Judging by the motion pictures, the radio, popular fiction, and the crowds that gather at the scene of automobile crashes, the average American family is not deeply impressed by the death of somebody else. Any appeal or teaching of home safety must be based upon pride in the individual's home or family, his love of gadgets, the admiration and pleasure he feels in developing smooth technique in anything, and the keeping up with the Joneses.

Statistics, like horror stories, create an immediate impression and call forth a gasp. The impetus then fades like the seed that fell in stony places and died because it had no roots. But some of the data do help to give a clear picture of the problem.

We find that nearly half of the home accident deaths were the result of falls,⁵ this being a major cause of fatal accidents among elderly people.⁶ The second greatest hazard in the home is from burns and explosions, which accounted for 17 percent of the deaths in 1938.⁷ A sickening number of these were children under five years.⁸ Then come poisonings, suffocations, poison gases, and firearms, no one of which accounts for more than five percent of home accident deaths.⁹

Among men, only heart disease ranks

higher as a cause of deaths than accidents. Among women, heart disease, cancer, cerebral hemorrhage, chronic nephritis, and pneumonia, in the order named, exceed accidents as causes of deaths. Among people from five to twenty years of age, accidents are, at all ages, the most important cause of death.¹⁰ These figures include all accidents.

SUMMARY

In summary: Home accident prevention is definitely a problem in America today. It can well come within the scope of a public health program, not only on the basis of the numbers involved, but also on the basis that there is something practical we can do about it. The public health nurse seems to be the logical person to act as the spearhead of any attack against this problem. She is psychologically in an excellent position to present this needed teaching because the door of the American home is open to her and because she has previously proved the value of her help to the family.

The nurse interested in home accident prevention must first acquire the simple factual foundation for her teaching. She must next train herself to observe accurately and analytically. Finally, she must develop techniques of smooth, deft, psychologically constructive individual teaching. The goal of the nurse in home accident prevention is to teach families to do *better* those things they are going to have to do anyway.

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CHOOSING ONE'S DOCTOR

SUGGESTIONS on how to choose a physician were offered by the United States Public Health Service in a mimeographed statement on May 26, 1939. These suggestions were presented merely to serve lay readers as a minimal guide rather than as a final set of rules. The statement is published here in part in the hope that nurses and lay readers will offer their opinions on the practicability of the advice given. We should welcome additional suggestions which may offer guidance to the lay person in choosing a reliable physician. An exchange of ideas on the subject which may be published in the forum "Our Readers Say . . ." would be stimulating, or comments and suggestions not intended for publication are invited.

It has been said that "it requires a medical education to enable a man to choose a good doctor."

This is hardly true.

The day, of course, when the family physician was almost a member of the family is about gone. Such relationships still exist in the hinterlands, and in rare cases in urban communities. These intimacies, however, are mostly reminders of an older day.

This is not to infer, on the other hand, that the choice of a dependable family physician is next to impossible. There are certain fundamental questions about the modern doctor to which one may seek answers, and upon these base an entirely satisfactory choice. In general, here is a good procedure.

If you plan to move into a new community, inquire of your own doctor at

your last residence, asking him to recommend a practitioner in the new town to which you are going. To check further, ask the secretary of your county medical society for a list of competent practitioners; ask the health officer of your city or county, or the secretary of the state medical association.

When first entering the new community, if you are not already supplied with doctors' names, ask at the hospital or local health office, or call the secretary of the local medical society and obtain a list of the general practitioners. Then make it your business to meet these men. Make specific and direct inquiries about what you want to know. If you are connected with some well established fraternal, church, or business group, make inquiry among your associates. The good physician will not only not

object to these personal inquiries; he will welcome them.

Here are questions to ask in connection with choosing a new physician:

1. Is he a graduate of a Class A school of medicine (as defined by the American Medical Association), or of a medical school known by recognized authorities as one of the best at the time he was graduated?

2. Is he a licensed practitioner in the state where he has office?

3. Has he had actual training as an interne in a hospital, or been associated with a practicing physician long enough to have obtained practical education in medicine?

4. Is he an active member of his local, county, and state medical society, and through them, of the American Medical Association, or any other recognized, organized body of physicians?

5. Is he of good personal habits, regarded by his fellow citizens as a desirable member of the community?

If he is the physician to fellow practitioners, that is an excellent guarantee of his ability. The fact that he is a member

of the staff of a well conducted hospital also indicates that he is usually a capable doctor.

These, too, are points to remember:

An ethical physician does not advertise his methods or cures in newspapers, give out circulars concerning his work or fees, indiscriminately distribute his picture, or put large signboards in his windows or outside his office to advertise his merits or wares.

Before considering any specialist, *per se*, consult your regular doctor and let him select the man if one is necessary.

No good doctor guarantees a cure. Avoid him who will "take no money until a cure is brought about"; this is a trick to snare the unwary. Likewise, avoid him who requires the fee in advance to cure a chronic disease.

Choose the doctor who works directly from his established residence or office and does not travel out of town or across state borders to seek his patient.

Avoid the boaster. A good doctor does not brag of his cures or suggest that they are made by secret methods. It is well to remember that there are no secrets in the medical profession.

CELEBRATE SAFELY

As a substitute for the old-fashioned custom of celebrating the Fourth of July with fireworks in the hands of individuals, the National Society for the Prevention of Blindness advocates community celebrations which include pyrotechnic displays supervised by experts.

Records of the American Medical Association show that at least 13 deaths and 5560 serious injuries of all kinds resulted from fireworks accidents during the observance of Independence Day in 1939. These included approximately 158 eye injuries, 19 of which resulted in blindness in one or both eyes.

The deaths of little children, the loss of sight, and the disfigurement of boys and girls as the result of playing with fireworks or other explosives—these are too high a price to pay year after year. It is the duty of everyone who values the

safety of children to see that laws prohibiting the sale of explosives are widely enacted and strictly enforced.

Reductions in the number of Fourth of July accidents have been brought about in hundreds of cities and towns throughout the United States which now have laws prohibiting the sale of fireworks. But the answer to the problem is the control of the manufacture and sale of fireworks through national and state legislation.

Nearly every city that has a fireworks ordinance is surrounded by good roads leading to suburban towns where fireworks are sold openly and legally. A few states have overcome this situation through stringent state laws. Real progress in making the Fourth of July a safe holiday can be achieved only by such statewide or national legislation.

These Lay Committees Work!

By MARY H. OXHOLM

Seven lay committees in this rural county comprise a nucleus of informed citizens to develop the program, support it, and interpret it to the community

TWO YEARS ago the first of seven lay committees interested in the public health program was organized in Ulster County, New York. This county is divided into 20 townships and the city of Kingston. Kingston and three towns each have their own public health nurse. Two nurses cover the other 17 towns, comprising a population of 35,979 people. The two nurses were put into this large area by the State Department of Health about three years ago. And while this is a story about the work of lay committees, it is really only a part of the nurses' own story, because they have been the motivating force behind the committees.

The first committee was established in the town of Esopus. The seventh, and latest, came into being in the town of Gardiner in October 1939. The other five are in the towns of Rochester, Plattekill, Shandaken, Shawangunk, and Ulster. The procedure of organization has been the same in each town; the nurse assigned to that area has found enough people interested in her work to have a group discussion, and the formation of a lay committee has followed automatically.

Our committees can only be formed with the sanction and approval of the Ulster County Medical Society, the District Office of the State Health Department, our town health officer, and our town supervisor. We now have their whole-hearted support as well as their approval. Our work has not been limited to infants and preschool children, but

our help is most needed and most effective in that field.

INITIATING CHILD HEALTH SERVICE

In areas where there has been medical approval for a child health conference, one of our first jobs has been to find suitable quarters for the conference. In one case a private citizen had a vacant building that he was glad to put at the committee's disposal; in another, a church gave its hall one day a month until the committee had convinced its own town board that the work was worth while and deserved permanent quarters. But in most cases the town boards have provided quarters for the conferences as soon as the need arose.

Our second step, of course, was to equip the conferences. We have done this by having food sales, card parties, teas, and other events to raise money, and incidentally, to advertise our work. We have bought scales, measuring boards, and blankets for use in the conferences. The equipment is simple and inexpensive, leaving a balance of funds for many other uses.

TRANSPORTING PATIENTS

Then comes the question of transportation. The towns are all very rural, with occasionally a good-sized village. Mostly they are very small hamlets and scattered farms. We try to have the conferences located in the largest villages, so that a good proportion of the mothers can perambulate their babies to them. Any family living beyond a rea-

sonable walking distance and without means of transportation is called for by a member of the committee, taken to the conference for consultation, and returned to its home.

Sometimes a member will drive six miles out into the country only to be met with the news that little Johnnie has a bad cold and cannot go that day. Such news has to be met with a smile. Perhaps he will be able to come next time. We know that a mother with small children and no telephone cannot leave them alone while she walks half a mile to the nearest telephone to notify us. And it does not happen very often. We also take patients to special clinics when necessary. All patients to be transported are given appointments by the nurse. The committee members are given their names and destination only. No questions are asked about the patients, and the committee members are not allowed at any time to mention names of patients among themselves.

This year dental consultations were added to the regular well baby consultations in all our conferences. Committee members are allowed to help the nurse in her field work in dental hygiene by calling on the mothers, explaining the purpose of the conference, and making appointments. We can also assist in controlling communicable diseases by visiting the homes, instructing the families, and gaining the parents' consents for toxoid and smallpox vaccinations. This is done only after we have had special instructions from the nurse. We all realize our limitations and are careful not to overstep them.

Most of the committees now supply codliver oil to be distributed by the nurse at her discretion.

We also make obstetrical bundles for home deliveries, which are kept in constant readiness at our health center for use by the local doctors. We now have a prenatal conference and we expect that service to be extended to the other

six committees as soon as their work reaches that stage. In these two ways we hope to help in bringing our maternity death rate down from its present peak of second highest in the state.

Several of the committees have found themselves so affluent that they have taken up a plan for tonsillectomies. Some have placed their problem before their health officer and he has helped to obtain the services of a surgeon. A plan has been developed whereby the committee pays for the hospital and the family pays the doctor whatever their budget will allow. People on relief are taken care of by the welfare officer. When the nurse finds a child urgently in need of this operation she tells the committee about it, never mentioning names of course. Then we look at our bank account and if we can afford it, the needed amount is appropriated. When the bill comes in the treasurer pays it, and she, the nurse, and the doctor are the only people who ever know who the patient is.

A BOMBHELL FALLS ON US

Early last September, just as everything was going along beautifully, a bombshell dropped in our laps. We heard from our district health officer that owing to a cut in funds the State Department of Health was removing one nurse from each district in the state. To us that meant that our child health conferences would have to be closed, since the one nurse who remained could not possibly do all the field work necessary. Something had to be done. So the presidents of the six committees which were then in existence had a meeting.

We went over the problem from every angle and decided that two roads were open to us. One was to go before the board of supervisors and ask it to take over the second nurse. But the work is comparatively new to the people in the county; the towns having committees

are still in the minority and our people do not yet know enough about the work to pay out willingly any more of their hard-earned tax money for the support of a nurse.

The other alternative was to ask the State Department of Health to find some way to carry the second nurse for us for one more year. We believed that in another year's time our work would have reached the point where the county would be fairly clamoring to take over the nurses and that we must make every possible effort to keep them. So we went to Albany to see the director of the Division of Public Health Nursing. We were received with the greatest kindness—and we got our nurse! Now we are bending all our efforts toward having the nurses made a permanent part of the health program in the county.

STUDYING OUR PROBLEMS TOGETHER

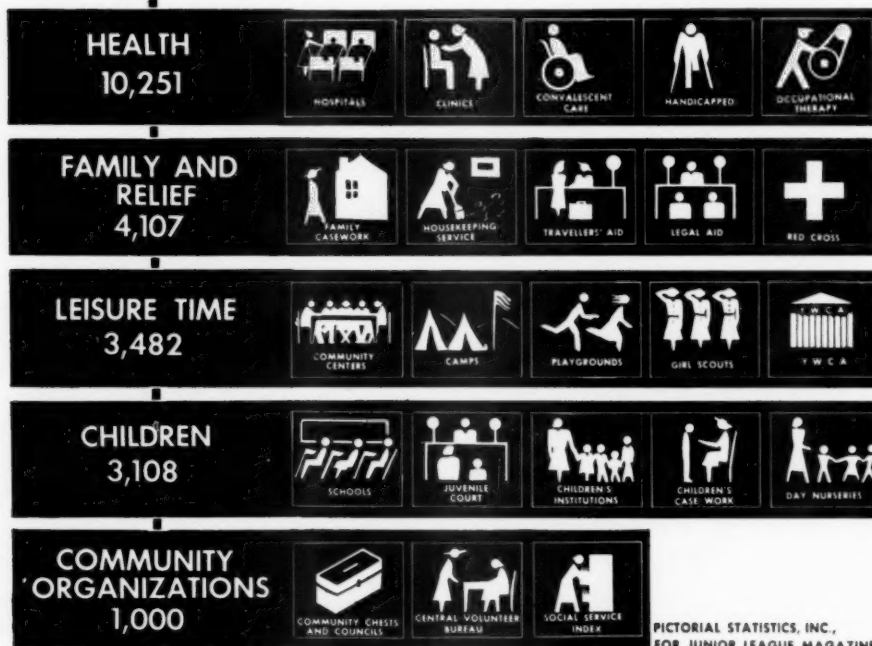
Late in October 1939 we held an all-day meeting of all the nursing committees in this region. The morning was devoted to group discussions of our various problems. The presidents formed one group, the secretaries and publicity committee chairmen another group, the treasurers another, and a fourth was made up of the nurses' aid committees which cover conferences, transportation, and supplies. We have correlated the notes made by these

groups and find they make a splendid handbook for our committees.

Just before luncheon we had two short talks on writing newspaper publicity, one by the managing editor of our largest county paper, and one by a reporter from another local paper who had done a good deal of health publicity work in cities. After the luncheon we had a short speaking program, with our district health officer acting as chairman. The program included talks on the public health movement—past, present, and future, community responsibility in public health, and a summary of public health work in the county to date. The meeting was well attended by the committee members themselves and there were a good many visitors from other towns and counties. A discussion period followed the speeches and everyone went home with a firm conviction that public health nursing must be made a permanent thing in Ulster County.

Since the first of the year we have secured the cooperation of our local radio station and have begun a three-months' series of weekly broadcasts. Each committee has taken one broadcast. Besides telling its history, each committee takes up one special phase of health work, such as nutrition or immunization. The series is closing with three talks on tuberculosis, cancer, and orthopedics, by committees specializing in those fields of work.





PICTORIAL STATISTICS, INC.,
FOR JUNIOR LEAGUE MAGAZINE

ACTIVITIES IN COMMUNITY SERVICES

THIS CHART represents graphically the first survey ever made of activities carried on by Junior League volunteers. The figures were computed from the response to a questionnaire sent by the Welfare Department of the Association of Junior Leagues of America to placement chairmen of 137 Junior Leagues. The total figures stand for activities of volunteers and not for the people carrying them out, since in many cases individuals are participating in more than one activity.

Virginia Howlett, secretary of the Welfare Department of the Association of Junior Leagues of America, planned the survey, devised the questionnaire, and

**CHILDREN'S
THEATRE**
3,496

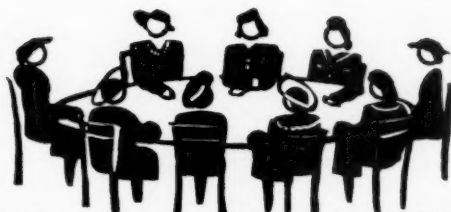


**VOLUNTEER
MONEY RAISING**
9,987



40,142

ACTIVITIES



COMMUNITY BOARD AND COMMITTEE MEMBERSHIP

CARRIED ON BY JUNIOR LEAGUE VOLUNTEERS

compiled the results. These statistics are of immeasurable value to every Junior League and to each department of the national association.

Junior League members serve their communities through 10,720 board and committee memberships. The number of board and committee memberships held in vital community agencies is one of great significance in that it indicates that membership in the Junior League does, in many instances, prepare individuals for active leadership in the community.

Reprinted with modifications from *Junior League Magazine*, February 1940.

Maternity Service—A Community Program

By LOUISE ZETZSCHE, R.N.

This maternity service coördinates the work of city and state agencies, and provides an educational experience for both medical and nursing students

THE MATERNITY PROGRAM of the Denver Visiting Nurse Association is essentially a community service, including such participating groups as the University of Colorado Medical School and School of Nursing, the clinic obstetricians, the state and city clinics, and county nurses throughout the state. The axis around which the community program rotates is the service offered by the visiting nurses.

In 1927 a member of the board of directors of The Visiting Nurse Association* visualized a service whereby Denver could contribute to a program of safer maternity care. The present program of antepartum, delivery, and postpartum service, whose tentacles reach far out into the state, is testimony to the action that followed this idea.

When the delivery service was first organized in 1927, one specialized nurse was assigned to the service for a period of a year. At the end of this time two nurses were added, and they carried on the delivery program in addition to the regular work of the districts. Under this plan the nurses assigned to the delivery service were partially specialized in that the most important phase of their work was delivery.

NOW PART OF GENERALIZED SERVICE

At the present time the delivery service is integrated in a generalized program. The nurses are on call from 8:00 a.m. to 3:00 p.m. in addition to the

many demands of a generalized program within their districts. Each district nurse is assigned the same hour daily at which to call the main office. If a delivery call is awaiting her at that time, she leaves her district and goes to the reported address to assist with the delivery. Four nurses are assigned to the night delivery service for a period of two months, and are on call from 3:00 p.m. to 8:00 a.m. This does not mean that each one is subject to call every night; the calls are rotated so that the nurses are on first, second, third, and fourth call in turn. Should a fifth call be reported, as happens occasionally, the supervisor of the service answers it.

TIE-UP WITH STATE HOSPITAL

One visiting nurse is in charge of the antepartum clinic at the university state hospital for a period of four months, during which she is in daily attendance. This nurse reports to the office of The Visiting Nurse Association each morning for one hour of consultation with the district nurses in regard to their maternity patients who are in attendance at the clinic. If an antepartum patient has a particular difficulty which cannot be untangled or interpreted in the office of the V.N.A., the record is taken to the clinic by the nurse for consultation with the clinic obstetrician.

When a patient presents herself to the antepartum clinic she is interviewed by the medical social worker, and referred to the clinic. After the physical exam-

*Mrs. May Farnum Woodward.

ination she is interviewed by the visiting nurse. This clinic interview is an important part of the maternity service. The physician's recommendations are interpreted, and plans for the delivery are made. If the patient is a primipara, or if a hospital delivery is advised by the obstetrician, the patient is referred to the hospital for delivery.

The conference is an excellent setting for teaching, for it is here that the delivery plan is made jointly by the nurse and patient. Pertinent points discussed at the clinic conference include the service offered by the clinic, for antepartum, intrapartum, and postpartum care; the appointments and their importance, with the underlying reasons why they should be kept; the home nursing service offered by the V.N.A.; and the importance of the postpartum examination.

The report of the physical findings about the patient is brought to The Visiting Nurse Association by the clinic nurse. The nurse for the district where the patient resides receives the report. When the nurse makes an antepartum visit to the home, she carries with her the report from the clinic and uses it as a guide for interpretation of the patient's visit, and also as a teaching tool.

The reasons for assigning a visiting nurse to the antepartum clinic are obvious. It is she who integrates the services of the V.N.A., the clinic, the physician, the interne, and the medical students, with regard to the patient. The benefit which the individual nurse derives from her clinic experience is three-fold. It gives her a greater appreciation of the physical, emotional, and financial difficulties of the patient; it makes her home instruction more productive; and it gives a clearer understanding of the use of records.

TEACHING OF STUDENT NURSES

The duties of the clinic nurse include the teaching of student nurses who are gaining their experience in obstetrics at

the hospital which operates the clinic. The experience of the student in the hospital is correlated with the clinic service, under the supervision of the visiting nurse in charge. The clinic experience of the student nurse includes the interviewing and history-taking of four patients in the clinic and visits to the home of each; the observation of two deliveries; a postpartum visit to two homes; and participation in the postpartum examination at the clinic.

After the student interviews four patients in the clinic she has an opportunity to select for intensive study and observation the case which is of greatest interest to her. The choice of four patients for student participation is made on the basis of proximity to delivery. When antepartum visits are made to the home by the visiting nurse, the student accompanies her. The student is present also at two deliveries in the homes. After her observation of the first delivery, an appointment is made for her to meet the district nurse in the home, in order that she may observe the first postpartum care given the patient. Generally this same patient is seen by the student at the postpartum examination. The plan for student participation is arranged so as to give her a complete picture of the in-service and out-service of a maternity program. At the end of this experience a case history is compiled by the student.

The educative process does not end with the teaching of student nurses, but includes another factor which constitutes a safe delivery; namely, the technique of a physician. The service which the clinic and the V.N.A. offer is one which prepares the patient physically and emotionally for what to her is the most important time in her pregnancy, the birth of her baby. The delivery techniques are planned for the safety of the patient; and these are also taught to the medical students of the University of Colorado, who carry on the home

delivery service in the city of Denver.

TEACHING THE MEDICAL STUDENTS

The personnel of a delivery in the home consists of an interne, a visiting nurse, and two junior medical students. Before medical students are assigned to the maternity out-service, a class in home delivery technique is taught at the medical school by the maternity supervisor of The Visiting Nurse Association.

When a patient is registered at the university hospital for home delivery, it is evidence that she has received the services of the clinic and The Visiting Nurse Association. The visiting nurse is acquainted with the home conditions of the patient through her antepartum visits there. She has assisted in planning the arrangement of the room for the delivery, the preparation of the bed and its location for adequate lighting, and home-devised equipment. This precision of organization adds a great deal to the comfort of the patient and the effectiveness of the physician's work. Adequate planning lessens effort—which otherwise would be wasted.

At the first signs of labor the patient calls the hospital, which in turn calls The Visiting Nurse Association if the delivery is during the day, or the home of the nurse on call if it is at night. The interne, the visiting nurse, and two medical students arrive at the home at approximately the same time.

The delivery is conducted by the two medical students, one having the responsibility for the delivery, and the other acting as assistant. Upon entering the home, which has been prepared by the family for the delivery, the medical students carry out the bag technique, prepare the patient, and arrange her in position for delivery.

Immediately after the delivery, the student who assisted takes charge of the newborn babe. In this capacity his duties are identical with those of a

nurse—or in some instances of a relative or friend. The medical student in charge of the delivery adds the finishing touch of giving complete care to the mother. The interne and visiting nurse, who are present at every delivery, act as advisers. The interne is present for consultation on medical procedure; the nurse on nursing techniques, which are adhered to meticulously. Complete care of the mother and the newborn infant includes nursing techniques, which are carried out by the medical students.

If the delivery is delayed, or if the call is false, the entire personnel leave the home together and return when needed. Under no condition is a nurse or medical student left in the home without the interne.

All delivery supplies are furnished by the medical service and brought to the home by the medical students. During the postpartum period, five visits are made by the medical service.

The home delivery service has definite educational value for the medical student. Few young physicians begin the practice of medicine in the higher economic brackets. Many will not have nurses as assistants, but will depend on members and friends of the family. The theory underlying the medical student's participation is that by having had actual experience under supervision of an interne and nurse, he has learned by doing. Furthermore, having the responsibility for the delivery prepares him to direct the family or friends who assist in home deliveries, and gives him confidence for the future when he is engaged in the practice of medicine.

The university hospital clinic is the interagent through which the services of the physician, visiting nurse, interne, medical student, and social worker reach the antepartum woman. From the clinic a report of the physical findings is sent to the various agencies interested in the patient. Since this is a state clinic to which patients come from all over the

state, the reports are not confined to the circumscribed area of the city and county of Denver, but reach far into remote sections of Colorado.

When a patient from a distant county receives care at the state clinic, a report of her examination and delivery is sent to the nurse in her county. Through such an arrangement the county nurse can do the follow-up work and she will have an early contact with the home for infant welfare visits.

The annual report for the year the service had its inception, 1927, showed a total of 102 deliveries. The maternal mortality rate in the city of Denver, where the home delivery service was offered, was 8.8 per 1000 total births. Since then the number of deliveries has increased steadily. As the service took root in the area, the program expanded, and the work of more nurses was required

to care for the increase in deliveries.

In 1939 the number of patients receiving delivery service was 623. The maternal mortality rate for Denver was 5.76 per 1000 total births.

Community interest, the system of reporting which extends into the state, the emphasis on the teaching of medical and nursing students, the teaching of mothers through the media of mothers' clubs and infant welfare stations, and home visiting—these are combined factors that have contributed to the improved picture shown in the annual report for 1939.

The present maternity program, which makes the process of reproduction a safer experience, is vivid evidence of the far-reaching effects of a board member's vision—a vision made a reality by the interest and support of The Visiting Nurse Association.

INTERPRETATION AND PUBLIC RELATIONS

What kinds of agencies employ workers for interpretation of their service to the public? Following are excerpts from a census of such positions

EARLY IN 1938 the Department of Social Work Interpretation of the Russell Sage Foundation embarked upon a census of positions in order to determine the extent to which interpretation and public relations services were emerging as a specialization in social welfare and health work. Functionally, the census drew its boundaries from the classifications and lists of national agencies given in the Social Work Year Book; territorially, it was confined to the United States, including Hawaii and the Canal Zone. Within these limits the canvass was intended to include public and private agencies—national, state, and local—in which substantial, regular

use of some type of paid service for interpretation or public relations might be found.

The positions concerning which information was sought were defined as follows:

A position in interpretation and public relations is considered to be one concerned primarily with plans and efforts, either on a year-round or an occasional basis, to disseminate information for such purposes as cultivating understanding and good will; securing financial support; inviting use of social and health services; promoting social legislation and other forms of social action; and carrying on popular health and welfare education.

Activities ordinarily assigned to such positions include writing of all kinds, notably stories and articles for news-

papers and special publications; preparation of appeal letters; promotion of money-raising, special events, and educational programs; pictorial publicity of many types, especially the preparation of exhibits, charts, and movies; organization of meetings and discussion groups; and securing opportunities for public speaking. This incomplete list is given here merely to suggest the area in which these positions normally develop.

Persons holding such positions are variously known as publicity directors or secretaries, directors of public relations, directors or secretaries of public information, educational secretaries, directors of public health education or information, editors, and workers specializing in such services as radio, press, speakers' bureau, and so on.

Agencies having public relations positions

Of the 2801 reporting agencies, 1887 use one or more of the six types of interpretative service listed in the questionnaire. However, only 1546 use paid service. Among the remaining 1255 agencies, 341 depended upon volunteers only; 767 definitely reported that they have no such service; while 147 merely returned the questionnaire without answering any of the questions. It seems safe to assume that the latter group also lack the services in question.

In the category, "Health and Mental Hygiene," tuberculosis societies, 178 in number, are most numerous, with a fairly even distribution of the remaining 109 among social hygiene, mental hygiene,

public health nursing, and cancer societies.

Summary of findings

As pathfinder for the study of positions in interpretation and public relations in public and private social welfare and health agencies in the United States, the census shows that of 2801 organizations replying to the questionnaire, 1887 make the following provisions for interpretation service:

Specialized service:

- 434 agencies employ 846 full-time workers.
- 209 agencies employ 289 part-time workers.
- 358 agencies employ free-lance workers.
- 151 agencies employ commercial firms.

Nonspecialized service:

- 932 agencies employ 1781 general staff members who, though chiefly concerned with other duties, give at least one-third time to interpretation.
- 844 agencies use volunteers.

These services are distributed in varying combinations among 205 public and 1682 private agencies. Three fifths of the organizations reporting such service, however, use only one type of service.

Interpretation service is to be found in all kinds of agencies. Public agencies are an important outlet for full-time specialized service. Volunteer service is almost entirely confined to the private agencies, which are also the heaviest users of free-lance writers and commercial publicity firms. Other types of service are scattered fairly consistently through the reporting group.

—Excerpts from *A Census of Positions in Interpretation and Public Relations*. Department of Social Interpretation, Russell Sage Foundation, New York, 1939.



Health in a Negro College

By CLARA B. HAMILTON, R. N.

This college has an integrated program of health service and health education whose ramifications extend into all phases of the student's experience

THE STUDENT health service at the West Virginia State College was inaugurated in 1924 as one phase of the development of a program in health education. The college, a land grant and state-maintained institution for higher learning for Negroes, is located in a beautiful spot on the picturesque Kanawha River nine miles from Charleston, the state capital. The village surrounding the school consists of about three hundred families. The college enrollment for 1939-1940 is 913, of which about half are men and half women. The faculty numbers 51, not including elementary school and extension teachers.

The student health service is a division of the Department of Health and Physical Education. Prior to 1924 the college had employed a part-time physician. In this year the director of the Department, believing that abundant health is an important factor in joyous living and in rendering the most efficient service to society, planned the first preventive effort at the college with the cooperation of the assistant field advisory nurse of the State Department of Health. One hundred and twenty-five freshmen—men and women—were examined by two physicians and two dentists. The nurse made a study of the findings. As a result of her recommendations a public health nurse was employed in 1925, and a three-bed infirmary for women was established in one of the dormitories. Six physicians, four dentists, and three nurses assisted in the



A student conference

physical examination of 335 freshmen in 1939, during the first week of school.

THE HEALTH PROGRAM TODAY

The health service personnel now consists of the medical director of the department, a part-time physician, a full-time nurse and four part-time nurses who are students in the college, two student assistants, one typist, and one junior premedical student who assists in the drug room and makes urinalyses.

A fee of three dollars a year is charged each student. This gives him the privilege of consultation on health problems, medical treatment at the dispensary, and infirmary or bedside care. It does not include hospitalization or special treatment, except in the care of athletic injuries.

The health offices, which are located in the gymnasium building, consist of a waiting room, a nurse's office and record

room, a physician's consultation room, an examination and treatment room, a drug room, and a first-aid room.

The health center is open daily from 9:00 a. m. to 5:00 p. m. except Saturday afternoon. The school physician is in his office on Monday, Wednesday, and Friday.

HEALTH APPRAISAL OF STUDENTS

Each new student is given a physical examination, and a personal and family history is taken. Sophomores also have physical examinations. All athletes and majors in physical education are examined each year. Students who return to school after an absence of one or more semesters have a reexamination.

Personal conferences are held with the students to acquaint them with the findings and to advise them about correction of defects. The student is responsible for securing needed treatment. Many have their corrective work done at home by preference. Through the cooperation of Charleston dentists and eye specialists, the school is able to get reduced rates for dental and eye corrections. Letters are written to parents when necessary, explaining the health needs of the student. Special attention is given to students with malnutrition, and through the cooperation of the dining department, additional milk is given them. An effort is made to arrange conferences before Christmas vacation with all students having correctable defects, so that necessary corrections can be made then if possible.

The student health ratings are A, B, C, and D: A—no apparent defect, activity unlimited; B—remediable defects, activity unlimited with observation; C—remediable defects which limit activities, restricted and corrective; D—constant supervision, no activity. The follow-up program is planned according to the classification of each student, whether A, B, C, or D.

Physical education activities, aca-

demic load, and student labor, as well as extracurricular activities, are checked, and recommendations made. Many of the students have to work in order to stay in school. The college provides many student labor credit jobs. It is the duty of the health service to prevent overloading.

BEDSIDE CARE OF STUDENTS

The nurses reside on the campus, one nurse in each of the three dormitories for women. There are also three dormitories for men. The nurses make daily visits to students confined to their rooms and assist with the care of patients in the infirmaries. The daily average in the infirmaries is four to six patients. The physician is available at any hour upon call, and makes visits to rooms without additional charge. All calls for the physician are made by the nurse on duty.

Names and conditions of students who are ill are reported daily to the office of the counselor of students. All students who are absent from classes on account of illness present a statement certifying this fact, signed by the school nurse.

A six-bed infirmary is located in a women's dormitory and a four-bed infirmary in one of the men's dormitories, for those suffering from minor illnesses. The rooms are arranged so that isolation is possible. Students who need special hospital care and who are unable to go home, are treated in Charleston hospitals where every consideration is given them.

Treatment by the college physician is not compulsory. The student may employ the physician of his choice at his own expense. Students are often referred to specialists by the school physician in order that the best possible care may be given in illnesses or injuries.

The state hygienic laboratory cooperates with the health service by mak-

ing blood tests, examinations of smear slides, and other tests free. X-ray pictures are made at a hospital in Charleston. Urinalyses are made at the health center. Blood tests are optional, except for food handlers, who are required to have them. About four hundred are done each year.

Vaccination for smallpox is required. Immunization for typhoid fever is not required but is offered annually. Tuberculin tests were given all new students in 1939 for the first time. X-ray pictures will be made of positive reactors. This program is made possible through the assistance of the Tuberculosis Association and the school health service of Kanawha County. The tuberculin is furnished free and x-ray pictures are made at a cost of one dollar a student.

Sanitary inspections of all dormitories are made by the nurse periodically and reports of conditions found are made to the director in charge of the building, with suggestions for changes needed.

LEARNING NEW PATTERNS OF HEALTH

Freshmen have a one-hour course in personal hygiene given by the director of the Department of Health and Physical Education. Monthly talks or group discussions dealing with special problems of health are arranged in the women's dormitories during the first five months of the term.

Personal conferences have been the most successful method of dealing with individual problems. Certain hours during the day are set aside for these and students with known problems are invited by letter to discuss them with the physician or nurse. Other students come in of their own accord. The health service endeavors to make every student experience and contact an educational one. Many of our students have their first physical and dental examinations when they enter the college, though the

number of these students is gradually decreasing due to the development of health programs in elementary schools in rural as well as urban sections. One of the most gratifying accomplishments of the service is the increasing use the students make of the health center for consultation. The average number of daily calls is thirty.

Students majoring in home economics are required to take a three-hour course in Home Hygiene and Care of the Sick, and a two-hour course in Problems of Child Care. Elementary teachers also take a two-hour course in health education, Materials and Methods in the Grades. These three courses are taught by the nurse. Physical education majors have a required course in health education taught by the director of health and physical education. The courses in health education are also offered during the summer session.

Since many students will become teachers or community leaders, practical programs which can be carried on in communities are demonstrated. Health literature is made available and used in programs and conferences, or placed in the waiting room where students will read it. Much use is made of visual materials such as posters, graphs, and pictures. Materials of the health center are lent to groups for exhibits and meetings.

The local American Red Cross chapter and the county branch of the National Tuberculosis Association cooperate with the health service.

PROGRAM IN PRACTICE SCHOOLS

The practice schools provide many opportunities for health education for teachers and experience in public health nursing for the nurses who are working toward their college degrees. Health courses are taught and activities are planned by the student teachers under the supervision of the critic teachers, who are given help by the college nurse.



Weighing babies at the health center

The required physical examination makes the student teacher conscious of his own physical status. The kindergarten children are inspected each morning by one of the nurses. The teachers inspect the children in the other grades. The elementary school is given health supervision by the county health service, but the pupils are brought to the health center for monthly weighing by the student teachers. In the high school the new students and senior students are examined each year by the college physician. The reports of physical conditions are sent to the principal, who notifies the parents by letter and refers them to the school nurse for further interpretation of the findings.

The science teachers in the high school are quite health conscious and work closely with the health service, using the teaching opportunities in their courses. They also help to plan the health activities for the school. At present, a program for boys and girls called "Building a Healthy Personality" is the outcome of the stated desire of the girls' club to improve their health. The nurse was invited to give talks to

the group on ways to improve physical health, and the psychologist from the college department is giving a series of talks on mental and emotional health.

A series of programs is planned each year for the regular assembly periods. Programs for this year include a moving picture on tuberculosis, which was sponsored by the class in health education and used to inaugurate the Christmas seal sale carried on by the class; an address by the director of oral hygiene of the Kanawha county schools; and a moving picture, "The Enemy of Youth," in connection with National Social Hygiene Day. Programs which included all schools on the campus were planned for National Negro Health Week. Students doing practice teacher work in the elementary and high schools took part in planning and carrying on the program. Activities consisted of talks, plays, exhibits, and an annual health week social sponsored by physical education majors. For the exhibits the Bureau of Public Health Education of the State Department of Health sends visual materials such as posters, displays, and motion pictures.



A college student assists at the child health conference

SERVING THE COMMUNITY

The health center not only serves the students of the college, but the community as well. People from the village call frequently for medical consultation and first-aid treatment. Annual pre-school and immunization conferences are projects for the community, sponsored by a college sorority which assumes responsibility for enrolling and transporting mothers and children, and for the physician's fee. Girls of the class in Problems of Child Care assist at the conference.

Immunizations for diphtheria, small-pox, and typhoid fever are furnished by the county health unit. This is an excellent example of what can be accomplished through the coöperation of groups interested in preventive activities. From time to time the nurse is invited to give talks to the parent-teach-

er group and other local clubs in the community.

Health work in a college is continuously interesting and stimulating. The constant contact with the many personalities on the campus, their problems and ambitions, keep one on the alert. The nurse must be prepared to keep a step ahead of inquiring minds and imaginations and must be convincing without arousing antagonism.

In spite of the signs of growing health consciousness of the students and the general good health of the group, the health service realizes that much needs to be done in order to improve the service so as to meet fully the modern standards for health service in colleges. We look hopefully forward to increased funds for improved facilities and an adequate personnel, so that more efficient service may be rendered.

Gleanings

Suggestions in regard to improvised equipment, methods of publicity, and new ideas that have proved practical are published in this column. Contributions are welcome.

THE REHABILITATION OF MRS. BROWN

MRS. BROWN, the 35-year-old mother of two school children, was stricken with poliomyelitis in September 1938. During her three months in the hospital she worried about conditions at home so much that it was obvious that an undesirable mental condition was developing. Her physician decided that it would be advisable to let her return home, if adequate facilities and competent nursing supervision could be secured. The service of the orthopedic public health nurse was requested.

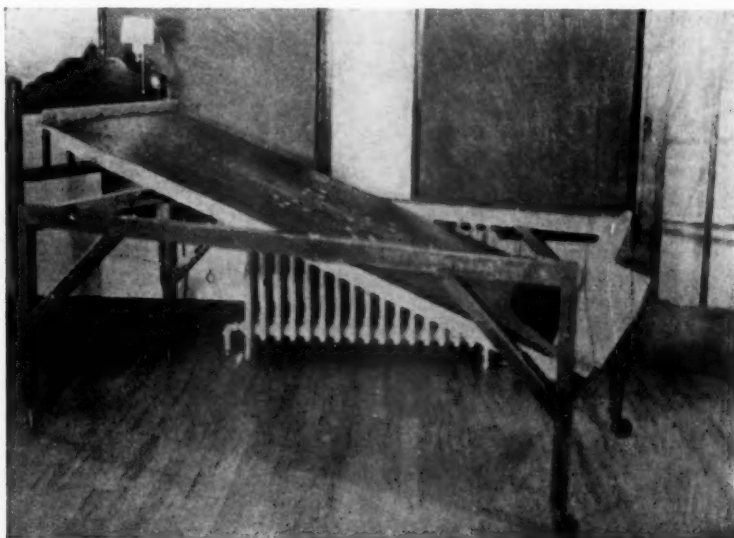
CONSTRUCTION OF SPECIAL BED

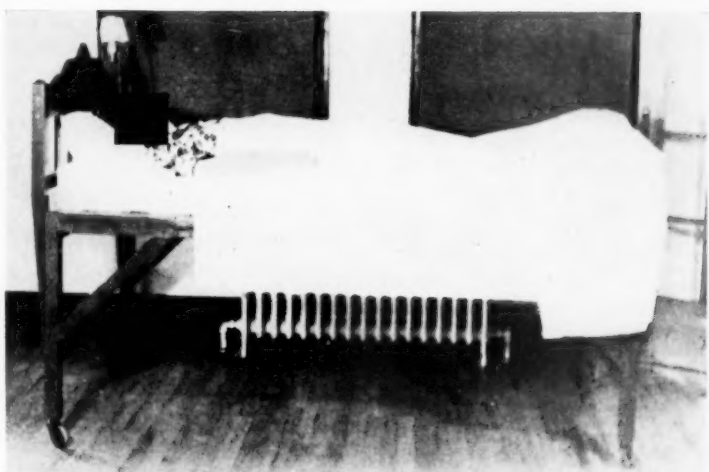
The patient had general paralysis following the poliomyelitis. The first requisite for adequate care was a bed comparable to that used in the hospital. With nurse's instruction and supervision, Mr. Brown constructed the bed which is illustrated here. It is made of

pine—though any substantial wood may be used. Plywood was utilized for the mattress board, with holes for ventilation in order to keep the mattress dry. The height is that of a regular hospital bed.

The foot-piece, which is detachable, serves the double purpose of holding the patient's foot in neutral position (at right angles to the lower leg)—and at the same time supporting the weight of the covers. When the patient is ready to get out of bed, the foot-piece is removed and the head of the bed is elevated, allowing her to slide down gradually and come to a standing position with very little assistance.

The advantage of this type of bed lies in the fact that the position prescribed for the patient can be maintained even when the head of the bed is elevated. It obviates the necessity of lifting the patient from the bed, with disarrange-





ment of position, which is so detrimental in cases with this type of orthopedic condition.

TREATMENT IN THE HOME

Upon the recommendation of the orthopedist, a series of treatments in physical therapy was started by a trained technician. The treatment consisted of baking, massage, and corrective exercises. The patient remained under the close supervision of the orthopedic nurse. Since it was important that the patient be kept in proper position to prevent possible deformities, careful instruction was given to the housekeeper who had been secured to take charge of the home. During this regimen the patient's mental and physical condition gradually improved.

When sufficient muscular power had developed in her upper extremities, occupational therapy was instituted. She learned to crochet, darned socks, mended clothing, and began to feel that she could assume her place in the home.

After a period of seven months in bed, double leg and back braces were applied, and Mrs. Brown was allowed to get out of bed. Previous to this she had been gradually elevated to an angle of 45 degrees for ten days; prior to that time

the bed had only been elevated for meals. Mrs. Brown did not experience any dizziness or faintness on being allowed out of bed. She was first allowed to stay up for a period of ten minutes. The time was gradually extended and she is now allowed to be up most of the day. She has taken over many of the duties of the housekeeper, including that of assistance in preparation of meals for the family, and she experiences a sense of pride in her accomplishments.

A homemade bicycle has been constructed by her husband and she is now using it to exercise her legs. She is also walking with the aid of braces, using the back of a chair for support.

The nurse has also assisted the family in meeting other problems. The older boy, who was suffering from spastic paralysis, has had an operation for stabilization of the foot. The younger boy, who is in good general health, has been referred to a physician for medical care of strabismus. The nurse has helped the family with planning their diet, budgeting their small income, and planning the housekeeper's day to allow an adequate rest period.

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The Recording of Home Visits

By GRACE HANSON, R.N., ESTHER DE VAL, R.N.,
and MARGARET G. ARNSTEIN, R.N.

Records kept by the public health nurse comprise a tool for effective family health service. A method for improving records of home visits is suggested here

ALMOST ANY public health nurse can give an answer to the questions: "Why keep family records?" "Of what use are the narrative notes?" Some of the usual reasons given are: to keep continuity in the visits; to make it possible for different nurses to carry the same case; to facilitate teaching on the next visit. These are all good and possibly sufficient reasons but they do not indicate *what* should be recorded in order to preserve this desired continuity in the teaching.

A study was made by the authors to determine why certain facts chosen from the whole visit were useful in the record and others were not. One method of making this type of study as objective as possible is to have several persons make records for the same home visit. Obviously this procedure is ordinarily impossible since only one nurse is present during most home visits. It was therefore decided to use the stenographic reports of home visits made by the United States Public Health Service in its study of the teaching content of visits. A random sample of these reports from the organizations studied in various parts of the country was made available through the courtesy of Dr. Mayhew Derryberry, who is in charge of the study.*

*"The Nurse as a Family Teacher," PUBLIC HEALTH NURSING, June 1938, p. 357; "How May the Nurse Become a Better Teacher?" *The Health Officer*, January 1939, p. 253.

The stenographer's report of each visit was studied independently by two experienced public health nurses, and each of them made narrative notations of the visit as though she were recording it herself. The nurses' experience and previous knowledge of the use of records were their only guides in the selection of material to be recorded or omitted from the record. A comparison of the records made by these two nurses and a comparison of their records with that of the nurse who had actually made the visit was made possible by breaking down the narrative into specific items of subject matter.

As the study progressed, the items which all agreed should be recorded were classified into certain general categories. The reasons for recording these items, which were derived during the discussions between the nurses, were noted under each category. The completed outline is presented below:

- I. Present physical or emotional status.
 - A. Normal physical or emotional status.
Reasons for recording these were:
 1. To indicate the reasons why advice or care was given or was not given during the visit.
 2. To indicate a possible reason for the family's interest or lack of interest in a particular health condition.
 3. To indicate a return to normal of a condition that had recently been abnormal.
 4. To indicate that a condition remained normal during a period when it sometimes becomes abnormal; for

example, blood pressure during pregnancy.

B. Abnormal physical or emotional status. Reasons for recording these were:

1. To indicate the reason why advice or care was given or was not given during the visit.
2. To indicate a possible reason for the family's interest or lack of interest in a particular health condition.
3. To indicate the need for immediate medical care.
4. To indicate conditions to be watched for on subsequent visits.

II. Social conditions.

A. Conditions that bear directly on the health problem in question. Reasons for recording these were:

1. To indicate action that should be taken or reasons for advice given.

B. Conditions that do not directly bear on this problem, but which incidentally came to light and might be important at a later date. The reason for recording these was:

1. To assist in further plans for the family.

III. Progress in knowledge regarding health, or in health habits and action. Reasons for recording these were:

1. To indicate where teaching can begin at the next visit.
2. To indicate the success of methods of instruction and to give some measure of accomplishments.

IV. Medical care of the family—past and present.

A. Medical care in the past. Care of past conditions indicates what the family's attitude toward the need for medical care has been in the past and what use they have made of medical facilities. The reason for recording this was:

1. To indicate what guidance should be given in this instance.

B. Present medical care. The reason for recording this was:

1. To know who should be called for orders or to whom a report of conditions found should be given. If no care is being given, the family might need assistance in arranging for care.

C. Physician's or clinic's orders and diagnosis. The reasons for recording this were:

1. To protect the nurse and her organization, by indicating why certain treatments were given.
2. To use in future visits in giving treatments and instruction.
3. To furnish permanent evidence of a given disease or condition.

V. Attitudes of the patient or family. Attitudes as interpreted by the nurse are recorded when actions or conversations of the family or patient which portray such attitudes are too lengthy to record. Reasons for recording these were:

1. To assist in the approach and teaching on subsequent visits.
2. To explain improvement or lack of improvement of certain conditions, since attitudes may be contributing factors in such improvement.
2. To enable the nurse to watch for changes in attitudes in subsequent visits.

VI. Care and teaching done by the nurse. Reasons for recording these were:

1. To know where to start care and teaching on the next visit.
2. To enable the nurse to watch for results of care or teaching.
3. To protect the nurse in case any question might arise as to what had or had not been done.

VII. Miscellaneous reminders for the nurse's use. Reasons for recording these were:

1. To note materials to be taken to family at time of next visit.
2. To note information to be gathered or passed on to others, such as social workers.
3. To remind the nurse of an appointment for the patient to be made before next visit.

The largest number of items recorded by all three nurses fell under the headings "present physical or emotional status" and "care and teaching done by the nurse." The items about which there was the least agreement fell under the heading "attitudes of the patient or family," and under notes about members of the family other than the one to whom the call was primarily made.

A number of items were recorded for which no valid reason could be found. This brought to our attention the fact

that though we are constantly striving to make our records brief, we still record bits of information without much thought as to why they are needed on the record. The elimination of useless notes will leave more time and space for necessary recording.

USE OF THE OUTLINE

The purpose of this study was to find a means of improving our recording. The above outline has been used in helping several students to improve the narrative notes on their records. The method of using the outline for this purpose is presented here with the thought that it might be used in the same manner by supervisors in the field.

The students read the stenographic reports of visits referred to on page 386. They then write narrative notes on the visits, and try to fit each item in their notes under some heading in the outline. If the notation does not fit into any category in the outline, and if the student can find some good reason for recording the item, she makes a new category. To date it has not been necessary to make any new categories. If on the other hand the item does not fit anywhere in the outline and no good reason for recording it can be found it should either be omitted or written in a different way. An example will illustrate the method.

Narrative notes for a visit to a five-months-old baby were recorded as follows: "Condition appears good. Discussed diet. Will bring baby to conference."

"Condition appears good" would belong under category I A, "normal physical or emotional status." An item is to be recorded under this category if it is needed to indicate the reason why advice or care was given, the reason for the family's attitude, a return to normal of a condition that had recently been abnormal, or the fact that a condition remained normal during a period of

strain. A further study of the visit record showed that none of these reasons applied in this instance, and it was decided this notation could be omitted.

"Discussed diet" would belong under category VI, "care and teaching done by the nurse," to be recorded for one or all of several reasons. It might be recorded in order to know where to start care and teaching on the next visit. The notation does not belong under this heading, however, since it does not show what the diet was, what was advised, or the mother's reaction to the advice. It might be recorded in order to watch for results of care or teaching. Since there was no indication as to what was discussed about diet, the nurse could not watch for results; therefore the notation does not belong under this heading. It might be recorded in case any question might arise as to what had or had not been done. It probably does belong here, since the notation indicates that diet has been discussed. The question arises whether the nurse intended to record this fact only for her own protection, and if so whether it is a justifiable purpose in this instance.

It was decided that probably the notation should have been made mainly for the first two reasons, VI, 1 and VI, 2. The student was then encouraged to study the visit and record the diet instruction given so that it would fit under these reasons, and the following notation was the result: "Suggested adding vegetables to diet. Mother understands their preparation." The notation will now fit under VI, 1 and VI, 2 since it gives the nurse a starting point for her next visit and also indicates what results may be expected. If on the next visit vegetables have been started, the nurse notes this as indicating "the success of methods of instruction" and "some measure of accomplishments" (III, 2).

"Will bring baby to conference" probably belongs under VII, 3 as a reminder

to the nurse to make an appointment or to watch for the patient. Or it might go under IV, B, 1, "present medical care," recorded in order to know who should be called for orders. In this case the nurse would find out before making the next visit whether the patient went to the child health conference and what the findings and orders were. This would appear to be a proper notation.

In this manner every record entry may be analyzed. In a short time the students are able to analyze their own notes and greatly improve their recording.

ANALYZING PLANS FOR VISIT

In addition to the use of this outline and along with it, another method has been found helpful. The student writes down her plans for the next visit. If the items in her plan are not derived from the information on the record nor from the general situation—for example, the fact that on the next visit the baby will be six months old and therefore immunization will be discussed—the nurse is asked why those items were included. Usually it is because of some information she knows but has not recorded. This

often helps her to see that no other nurse could plan the visit from the available information. In fact, she herself might forget the information which she was carrying only in her mind.

One of the authors has attempted to assist students in record work by the usual methods, first reviewing with the students the general principles regarding records, and then analyzing each entry. In each instance the student was asked to indicate how she would use the notes on the record and was given assistance in rewriting them. The students did not show much improvement in their ability to write the notations even after several conferences of this type.

Then the outline which had previously been worked out was given to them. The students and the writers agree that the use of the outline as described in this article gives a better understanding of methods of recording than was obtained through the other educational procedures. Although the method has not been tried as yet in a field agency under working conditions, it is hoped that it will prove a useful tool in the field as well as in the classroom.

Interpreting Health Service to the Teacher

WHEN THE Coöperative Health Unit of Tahlequah, Oklahoma, was asked to give some classes in school health to the summer school students in the state teachers' college, it was considered a great opportunity to interpret our work to the teacher. These students included rural and city teachers as well as prospective teachers, representing 21 counties.

A series of four lessons was planned. The first consisted of a talk by the medical director of the district health unit on the coöperation of the State Depart-

ment of Public Health with the teacher. The second was a discussion of a bulletin—with which each teacher was supplied—on the three things that comprise the school: the teacher, the child, and the school plant. The third lesson was the demonstration of weighing and measuring and the testing of vision and hearing, to be done by the classroom teacher. The vision and hearing tests were introduced as games. The audiometer test was given the class of teachers, not only to find their defects, but to make them more conscious of the hearing problems



The nurse and the teacher confer on school health needs

of the children. The fourth lesson was on dental education, and two dental motion pictures suitable for the children were shown.

During these classes the material and services available through the state health department were explained and the services of the district or county nurse were stressed.

A display room was used for school health displays. In this room the following material was displayed: a hand-washing setup for a rural school; a first-aid cabinet made by a small boy from a dried peach box; health work done by children in various schools. The correlation of health with art, writing, spelling, and many other subjects was discussed. There were various health books showing the modern methods of correlating health, other health materials that may be obtained free, posters emphasizing positive health, and copies of suggestions for health activities.

The teachers seemed very much interested in this new venture. When the lessons were finished, they were asked to answer the following five questions:

What are the health needs in your school? How can they be improved?

What facilities (such as clubs) do you have in your community for aid to the school health service?

What help have you received from the school health lessons given by the state health department?

What suggestions do you have to offer the public health nurse for a better school program?

Who is the nurse in your district?

The answers to these questions are very interesting and will give the nursing service something to work from in making future plans.

TRESSA WALTERS, R.N.
State Health Nurse
Coöperative Health Unit
Tahlequah, Oklahoma

Information Please

By LOUISE HOPWOOD

Part II

Information on the minimum and maximum salaries, methods of coordination of services, changes in program, and special agency studies are included here

THIS IS the second in a series of four discussions based on answers which agencies sent in on the Yearly Review schedules of the National Organization for Public Health Nursing. There were 594 agencies which replied in 1938 to the questions, and those giving information on the subjects discussed here include 225 nonofficial agencies, 194 health departments, and 119 boards of education.

MINIMUM AND MAXIMUM SALARIES

Minimum salaries of staff nurses are apparently higher in health departments than in nonofficial public health nursing agencies. Only 3.6 percent of the minimum salaries in health departments were stated to be less than \$100 a month, whereas 8.4 percent of the minimum salaries in nonofficial agencies were so stated. Furthermore, 3 health departments gave minimum monthly salaries of more than \$160, whereas no nonofficial agency paid more than \$160. The highest beginning salary among the nonofficial agencies was \$150.

Among the 7 health departments that started their nurses at less than \$100 a month, the maximum which any nurse could expect was \$150. Among the 19 nonofficial agencies that started their nurses at less than \$100 a month, the highest salary offered was also \$150.

There were 41 health departments whose minimum salaries were in the \$130-159 category. The highest maxi-

mum available for these was over \$180, and 5 of these health departments gave such maximums.

There were only 20 nonofficial agencies whose minimum salaries were in the \$130-159 category. The highest maximum available for these was also over \$180, but only one organization offered such a maximum.

How long does it take a nurse who starts at the minimum salary to reach her maximum salary? In 117 nonofficial agencies replying to this question, 72 percent reached their maximum salary before four years of employment; whereas only 62 percent of the 60 health departments which gave usable information reached their maximum before four years.

The reason most often given in both types of agencies for salary increases was "length of time of employment." These factors, or a combination of these three factors, time, merit, and education, formed the criterion for increase in the majority of agencies giving usable information. The decision of the governing body in health departments was given as the determining factor in increases in 13 agencies but was not mentioned in the nonofficial agencies. There were 10 nonofficial agencies and 28 health departments which did not grant any salary increases.

Salaries of nurses working under boards of education are stated on a yearly rather than a monthly basis. Of the 95 boards of education which specified their minimum yearly salaries for 1938, 27 agencies started their nurses at \$1200 to \$1299 a year. The range in

TABLE I
COMPARISON OF MINIMUM AND MAXIMUM SALARIES OF STAFF NURSES IN HEALTH
DEPARTMENTS AND IN NONOFFICIAL AGENCIES IN 1938

Health departments										Nonofficial agencies				
Total health depart- ments		Maximum salaries								Total nonofficial agencies	Maximum salaries			
		\$100-119	\$120-139	\$140-159	\$160-179	\$180 and over not stated	\$100-119	\$120-139	\$140-159		\$160-179 and over not stated			
Minimum salaries														
Total agencies	104	11	43	43	15	8	74		225	18	71	69	9	1 57
Less than \$100	7	3	1	1	—	—	2		19	7	8	1	—	3
\$100-129	99	8	36	23	7	2	23		151	11	59	58	4	19
\$130-159	41	—	4	17	8	5	7		20	—	1	9	5	1 4
\$160 and over	3	—	—	—	—	1	2		—	—	—	—	—	—
Minimum not stated	44	—	2	2	—	—	40		35	—	3	1	—	31

beginning salaries is from \$850 to \$2100 a year. The most usual maximum salary in the 85 agencies answering this question was from \$1800 to \$1899 a year. The range in maximum salaries in boards of education was from \$900 a year to \$3600 a year. It takes a school nurse a much longer period of time to reach the maximum than it takes the nurse in either nonofficial agencies or health departments, but the maximum is higher. Of the 58 agencies giving this information, 33 agencies expected from 5 to 10 years service, and 13 agencies required 10 years or longer before the maximum salary was paid. Forty agencies gave as their reason for salary increases, length of service. The other reasons given were merit, education, and experience, or a combination of these factors. There were 11 agencies which did not have planned salary schedules, and 9 agencies did not give increases. For 26 agencies this information was not given.

COORDINATION OF SERVICES

A question was asked in the 1938 Yearly Review about the coordination of nursing services within the community, since such coordination helps to eliminate duplications and gives a more economical nursing service.

Table II shows that the most usual

method of coordination among non-official agencies was through the service of the health officer on the board or medical advisory committee of the non-official agency. Other methods are affected by the size of the community in which the agency is located, because sometimes the nursing agency is the only welfare organization. This information was tabulated according to size of agency. The size of the agency is with few exceptions in proportion to the size of the community served. The exceptions are agencies in urban populations doing a specialized service, or agencies serving a large rural population.

The number of methods of coordination used by the agency decreased as the size of the agency decreased. It is of interest that the method most seldom used was the nursing council. There were 85 agencies which gave other methods of coordination, the case conference being used most frequently.

CHANGES IN PROGRAM

The N.O.P.H.N. hoped to get information on new emphases in the field of public health nursing as shown in the changes of programs reported in the 1938 Yearly Review schedules. In general the reports show expansion in the types of services offered, better coverage of the population, and better coordination

TABLE II
METHODS USED FOR COORDINATION OF NURSING SERVICE WITHIN THE COMMUNITY

Method of coordination	Total agencies	Answers to questions on coordination				
		Used method indicated	Replies not usable ¹	None in community	Did not use method indicated	Question not answered
Council of social agencies	225	82	76	12	—	55
Health council	225	46	39	21	3	116
Nursing council	225	23	34	31	8	129
Health officer on board or medical advisory committee of nonofficial agency	225	91	67	—	13 ²	54
Joint staff meetings	225	56	39	—	19 ³	111

¹ These agencies merely answered with a check or cross, which could not be interpreted

² Two agencies stated there was not a health officer in the community.

³ Two agencies stated they were the only agency in the community.

tion of the various services. The types of new clinics organized in 1938 represent an interesting comparison between nonofficial and official agencies. The clinics organized by the former covered a wide range of services, the most popular being well baby conferences. Dental, toxoid, tuberculosis control, pneumothorax, contraceptive, child habit, and mental hygiene clinics were also mentioned. The official agencies showed less variety in types of clinics, the majority being clinics for syphilis and gonorrhea, well baby conferences, and antepartum clinics.

Many nonofficial agencies in many states were enlarging their services. Some of the agencies started crippled children services; others started nursery school inspection and work with preschool children. The agencies were also protecting the parents through mothers' classes and home delivery services and by going into industrial plants to give nursing service on an hourly basis for the protection of the wage earner. Two agencies mentioned that they planned to provide 24-hour bedside nursing care in their communities.

There were some indications of reduction in service, also. In one community the agency limited its health service to children under two years of age; another had discontinued its child guidance clinic. However, the picture as a whole is one of growth.

One agency employing six nurses had made such a success of a special drive for funds that they employed a physical therapist from the proceeds. Another agency in the Middle West started a maternal milk laboratory and special care for premature infants. In another city, the health record of a preschool child starting to school is sent to the school. Formerly the preschool record was closed and filed away where it would

be of no use to the teacher or the nurse.

One of the noteworthy changes of program in health departments in 1938 was the change from specialized to generalized service. Ten health departments reported this. Two places reported that in 1938 they divided their territory into districts. Several communities coordinated their nursing services by a combination of agencies. One health department and one nonofficial agency joined forces to establish a single nursing service. In two communities the county and city health units combined, and in one community the school nursing service combined with the local health department.

The boards of education are expanding their programs to include the high schools, especially with respect to tuberculin tests and x-ray pictures. Two organizations reported they had instituted a dental program with full-time dentists. One city said they were having success with student health committees in the schools.

SPECIAL STUDIES

Among the wholesome signs of growth is a developing interest in special studies. In 1938, 123 organizations made special studies. It is of interest that all sizes of agencies are represented among these. In nonofficial agencies and health departments the most popular subject for study was maternity work. There were 16 studies on that subject. In health departments, communicable diseases were the subject of a large number of studies.

The boards of education reported more studies per agency than either the nonofficial agencies or health departments. There were 14 studies based on hearing and vision tests. Studies on vaccinations and immunization accounted for 9, and 7 tuberculosis and x-ray studies were made.

News from the S.O.P.H.N.'s

THE NEW Jersey State Organization for Public Health Nursing celebrated its twenty-fifth anniversary at its annual meeting at the Berkeley-Carteret Hotel in Asbury Park, April 19, 1940.

Meetings of the four sections—board members, child hygiene, school nursing, and social hygiene—were held after the business meeting in the morning.

The silver anniversary luncheon was a gala occasion with over six hundred nurses and interested laymen attending. Twenty-five nurses in uniform marched into the room, each carrying a lighted candle. These were placed around a birthday cake on the speakers' table, where honorary members and past presidents were seated.

The past presidents and charter members were introduced by Nellie Ogilvie, president. A short account of the founding of the organization was given by the first president, Frances Dennis. An outline of the organization's history for the past 25 years was given briefly by Evelyn T. Walker, director of the Public Health and Welfare Department, Monmouth County Organization for Social Service, Red Bank. Miss Walker was introduced by the program chairman, Marion Warren, high school nurse in Audubon, New Jersey.

Humor and seriousness were mingled in a dialogue, "Then and Now," presented by Margaret Leavitt and Mildred Gonyeau, contrasting the work of a public health nurse in 1915—who appeared on a bicycle carrying a Boston bag—and the nurse of today in her trim uniform with the standard black bag on her arm. The audience learned from this skit how public health nursing has

enlarged its scope in twenty-five years.

Dorothy Deming brought greetings from the National Organization for Public Health Nursing and told of the progress of public health nursing in the past quarter of a century.

In the address of the afternoon on "Public Health Nursing—Yesterday, Today, and Tomorrow," Dr. C.-E. A. Winslow of the Yale University School of Medicine reviewed the steps in our progress and pointed out what he considered to be the major problems of the future. Dr. Winslow named four present trends which will influence public health nursing in the future: collective bargaining, the housing movement, the social security program, and plans for the extension of medical care including prepayment plans. He said that one family out of every hundred in a given year pays a fourth of its income for medical care, and that the only remedies for this unequal distribution of the costs of medical care are (1) voluntary group health insurance for those of moderate means (2) compulsory health insurance for low-income groups. Quoting the figures presented at the White House Conference on Children in a Democracy that a third of the population of the United States has an annual cash income of less than \$800 and two thirds an income of less than \$1500, Dr. Winslow said that the problem of poverty is the greatest problem now facing the American people. He emphasized the fact that a great deal of poverty is due to illness and that on the other hand many are sick because of poverty.

ELIZABETH CURTIS, R.N.
*Chairman of Publicity
New Jersey State Organization
for Public Health Nursing*

Your N.O.P.H.N.

PICTURES of early visiting nurses soon after the turn of the century show them in long dresses and large hats climbing tenement stairs to care for newborn babies and their mothers or to nurse sick mothers and infants. Since the Social Security Act was passed in 1935, rural mothers and infants are beginning to receive the same health protection as those in cities. Public health nurses are now giving service in innumerable communities which could never before afford a nurse.

The National Organization for Public Health Nursing has always considered maternal and child health to be one of the most important fields of service of the public health nurse. Her responsibilities in regard to the health supervision of mothers, infants, and preschool children are defined in the "Functions in Public Health Nursing," published by the Organization in 1936.* The N.O.P.H.N. is especially interested in the integration of maternal and child health services into the entire family health program. The Organization endeavors to keep abreast of the latest information and the accepted standards and procedures in these fields and to make them available to nurses through the magazine, through reprints of articles, through the *Manual of Public Health Nursing*,** through bibliographies, and through up-to-date lists of sources of free and inexpensive materials such as pamphlets, posters, films, and slides.

The advisory service of specialists in maternal and infant care is made avail-

able to N.O.P.H.N. members through its Council on Maternity and Child Health, which is composed of obstetricians, pediatricians, mental hygienists, nutritionists, dentists, nurses, and other professional workers especially interested in these fields. Its members serve in an advisory capacity in regard to any questions of a technical nature which the N.O.P.H.N. staff needs assistance in answering. The members help to secure authoritative authors for magazine articles, evaluate material that has been submitted, review books, assist in the revision of bibliographies, assist with the preparation of maternal and child health material in the *Manual of Public Health Nursing*, and serve on committees concerned with special problems such as the revision of nursing records or the study of delivery services. A staff member serves as secretary of the council.

The N.O.P.H.N. works closely with various organizations concerned with maternal and child health, such as the United States Children's Bureau, the Maternity Center Association, and The American Committee on Maternal Welfare. It belongs to the National Council for Mothers and Babies which was organized to coördinate the efforts of sixty professional and lay organizations interested in these problems. The N.O.P.H.N. represents its membership at important meetings such as the following:

The White House Conference on Children in a Democracy (see March 1940 issue, page 139)

National Health Conference (September 1938 issue, page 546)

Conference on Better Care for Mothers and Babies (February 1938 issue, page 71)

The First American Congress on Obstetrics and Gynecology (November 1939 issue, page 594)

The president of the N.O.P.H.N., Grace Ross, was a member of the Plan-

*"Functions in Public Health Nursing." PUBLIC HEALTH NURSING, November 1936, p. 732.

**National Organization for Public Health Nursing. *Manual of Public Health Nursing*. The Macmillan Company, New York, revised edition, 1939.

ning Committee of the White House Conference, and a staff member served as nursing chairman of The First American Congress on Obstetrics and Gynecology.

The National Organization participates in various activities and works coöperatively with other groups through staff membership on committees such as the Advisory Committee of the Summer Roundup of the Children of the National Congress of Parents and Teachers; the Advisory Council and the Consultants' Committee of the National Association of Day Nurseries; and a joint com-

mittee with the National League of Nursing Education to outline the content of a postgraduate course in maternal health. The general director is a member of the General Advisory Committee on Maternal and Child Welfare Services of the United States Children's Bureau.

In short, the N.O.P.H.N. is vitally interested in all phases of maternal and child health, particularly those which touch on the function of the nurse—and what phases do not!

PURCELLE PECK, R.N.

Assistant Director



ADDITIONAL SUMMER COURSES

American Red Cross teacher training courses for instructors in Home Hygiene and Care of the Sick, in coöperation with:

University of California at Los Angeles, Los Angeles, California.....	July 1-August 9
Colorado State College, Fort Collins, Colorado.....	July 6-August 16
George Peabody College for Teachers, Nashville, Tennessee.....	June 10-August 23

For further information write to Nursing Service:

National Headquarters, American Red Cross, Washington, D.C. (for Eastern Area); Midwestern Branch Office, American Red Cross, 1709 Washington Avenue, St. Louis, Missouri (for Midwestern Area); Pacific Branch Office, American Red Cross, Civic Auditorium, San Francisco, California (for Pacific Area).

New York

New York. New York University. July 2-August 9. A course on A Survey of Eye Conditions (4 points credit) to be conducted by an ophthalmologist for students in the summer session. This course has been offered by New York University since 1932 in coöperation with the Bureau of Services for the Blind, New York State Department of Social Welfare. It is designed for workers in the fields of education, social welfare, nursing, and allied fields, and aims to give a knowledge of eye conditions as related to problems of general health and welfare with emphasis on the need for sight conservation and preventing blindness.

For program giving outline of lectures write to Ruth McCoy, Bureau of Services for the Blind, New York State Department of Social Welfare, 205 East 42 Street, New York, N.Y.

NOTES *from the* NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

JUNE—THE HONOR ROLL MONTH

Let's make June the banner Honor Roll month for 1940! To earn your Honor Roll Certificate during the N.O.P.H.N.'s birthday months would be a fine way to celebrate the occasion and to show your loyalty.

The 100 percent membership in the N.O.P.H.N. of your staff is all that is necessary for your agency to be eligible for the Honor Roll. If you are a one-nurse agency and you are an individual member, your agency is entitled to a Certificate. Just as soon as you are eligible, let us know so that the name of your agency can be added to the imposing list and your Certificate sent.

Already more than 600 agencies have received their Certificates of Honor. If you are not one of the 600, let's hear from you before the month is over. Won't you try for 100 percent membership in June and send your dues now; it will do a great deal toward making June a banner Honor Roll month?

ALABAMA

Marion County Health Department,
Hamilton

ARIZONA

Phoenix Union High School, Phoenix

ARKANSAS

Madison County Health Unit, Huntsville

COLORADO

Cheyenne County Public Health Nursing
Service, Cheyenne Wells
Elbert County Public Health Nursing
Service, Kiowa

CONNECTICUT

Collinsville Branch of American Red
Cross, Visiting Nurse Association, Avon
Heights
North Canaan Visiting Nurse Association,
Canaan
Cheshire Public Health Nursing Associa-
tion, Cheshire
Clinton Public Health Nursing Associa-
tion, Clinton

*Public Health Nursing Association, East
Hampton

Groton Visiting Nurse Association,
Groton

*Public Health Nurse Association, Guil-
ford

*Haddam Public Health Association,
Haddam

Hamden Public Health and Visiting
Nurse Association, Inc., Hamden
Public Health Association of the Town
of Essex, Ivoryton

*Salisbury Public Health Nursing Associa-
tion, Lakeville

Madison Public Health Nursing Associa-
tion, Inc., Madison

Public Health Nursing Association of
Mansfield, Inc., Mansfield

*Naugatuck Chapter, American Red Cross,
Naugatuck

*Visiting Nurse Association, New Canaan
Public Health Nurse Association, New-
ington

New Preston Visiting Nurse Association,
New Preston

*Newtown Visiting Nurse Association,
Newtown

Norwalk Health Department, Norwalk

*Old Lyme Branch, American Red Cross,
Old Lyme

Plainville Public Health Nursing Associa-
tion, Plainville

*Portland District Nurse and Welfare
Association, Portland

*Red Cross Public Health Service, Putnam
Lime Rock-Falls Village Public Health
Nurse Association, Lime Rock Center
Stafford Chapter American Red Cross
Nursing Service, Stafford Springs

East Windsor Public Health Nursing
Association, East Windsor

Washington Visiting Nurse Association,
Washington Depot

District Nurse Association of Moosup,
Wauregan

Public Health Nursing Association of
Cornwall, West Cornwall

*Visiting Nurse Association of the Town
of Windham, Willimantic

Windsor Locks Public Health Nursing
Association, Windsor Locks

Woodbury Red Cross Community Nurse
Association, Woodbury

DISTRICT OF COLUMBIA

Kiwanis Club Clinic for Crippled Chil-
dren, Washington

*United States Public Health Service,
Washington

GEORGIA

*The Savannah Health Center, Savannah

*Agencies on the Honor Roll five years or more.

Bullock County Health Department,
Statesboro

ILLINOIS

- Boone County Public Health Nursing Service, Belvidere
- *Metropolitan Life Insurance Nursing Service, Chicago
- Lake County Tuberculosis Association, Waukegan
- *Winnetka Family Welfare Society, Winnetka

INDIANA

- *Red Cross Public Health Nursing Service, Fort Wayne
- *Visiting Nurse League, Fort Wayne
- Decatur County Nursing Service, Greensburg
- *Huntington Schools, Huntington
- *Bureau of Public Health Nursing, State Board of Health, Indianapolis
- *LaGrange County Health Nursing Service, LaGrange
- *Metropolitan Life Insurance Nursing Service, Michigan City
- *Floyd County Tuberculosis Association, New Albany
- *Metropolitan Life Insurance Nursing Service, New Albany
- Metropolitan Life Insurance Nursing Service, Vincennes

IOWA

Health District No. 1—Iowa State Department of Health, LeMars
East Waterloo Public Schools, Waterloo

KENTUCKY

Clinton County Health Department, Albany
Metropolitan Life Insurance Nursing Service, Ashland

MAINE

- Brunswick Chapter, American Red Cross, Brunswick
- *Androscoggin Anti-Tuberculosis Association, Lewiston
- *Rumford School Nursing Service, Rumford
- *York County Chapter, American Red Cross, Saco

MARYLAND

Metropolitan Life Insurance Nursing Service, Hyattsville

MASSACHUSETTS

- *Arlington Visiting Nursing Association, Arlington
- *Cambridge Visiting Nursing Association, Cambridge
- *Visiting Nurse Association, Great Barrington
- *Franklin County Public Health Association, Greenfield
- *Lynn Visiting Nurse Association, Lynn
- *Milford, Hopedale, Mendon Instructive District Nursing Association, Milford
- *Newton District Nursing Association, Newtonville

Northampton Visiting Nurse Association, Northampton

Berkshire County Tuberculosis Association, Pittsfield

*Quincy Visiting Nurse Association, Inc., Quincy

*Richmond Community Health Association, Richmond

Waltham District Nursing Association, Waltham

*West Springfield Neighborhood House Association, West Springfield

Winchester District Nursing Association, Winchester

MICHIGAN

- *Children's Fund of Michigan, Detroit
- *Ann Arbor Public Health Nursing Association, Ann Arbor
- *City of Grand Rapids Health Department, Grand Rapids

MINNESOTA

Litchfield School Nurse Service, Litchfield

*Community Health Service, Minneapolis

Hennepin County Rural Public Health Nursing Service, Minneapolis

Olmsted County Public Health Nursing Service, Rochester

MISSOURI

Barry County Public Health Nursing Service, Cassville

Missouri State Health Department, District No. 2, Dexter

State Department of Health, Division of Public Health Nursing, Jefferson

State Board of Health of Missouri, District No. 10, Kirksville

State Board of Health of Missouri, District No. 9, Owensville

Missouri State Health Department, District No. 6, Ozark

MONTANA

Pondera County Public Health Nursing Service, Conrad

NEBRASKA

Dundy County Public Health Nursing Service, Benkelman

NEW HAMPSHIRE

*New Hampshire State Board of Education, Concord

*Lancaster Chapter, American Red Cross, Lancaster

*Portsmouth District Nursing Association, Portsmouth

NEW JERSEY

Atlantic Visiting Nurse and Tuberculosis Association, Atlantic City

*Bridgeton Chapter, American Red Cross, Bridgeton

Board of Education, Clifton

*Metropolitan Life Insurance Nursing Service, Dover

*Agencies on the Honor Roll five years or more.

- *Elizabeth Visiting Nurse Association, Elizabeth
- Hudson County Metropolitan Nursing Service, Jersey City
- Board of Education, Keyport
- Maywood Public School, Maywood
- *Moorestown Visiting Nurse Association, Moorestown
- New Jersey State Teachers College, Newark
- *American Red Cross, Perth Amboy Chapter, Perth Amboy
- *Monmouth County Organization for Social Service, Inc., Red Bank
- *Red Bank Public Health Nursing Association, Red Bank
- Lowe Paper Company, Ridgefield
- *Salem Child Welfare and Visiting Nurse Association, Salem
- Dover Township Board of Education, Toms River
- Visiting Nurse Association, Trenton

NEW YORK

- Akron High School, Akron
- *Erie County Health Service, Buffalo
- Steuben County Public Health Nursing Committee, Corning
- Metropolitan Life Insurance Nursing Service, Cortland
- Maternity Center Division of the Visiting Nurse Association, Brooklyn
- *Buffalo Tuberculosis Association of Erie County, Buffalo
- Metropolitan Life Insurance Nursing Service, Fulton
- Metropolitan Life Insurance Nursing Service of Babylon, Hempstead
- Queens Metropolitan Central Nursing Staff, Jamaica
- New York State Department of Health, Lowville
- *Town of Marlboro Nursing Service, Milton
- *Visiting Nurse Association, Mt. Vernon
- *National Society for the Prevention of Blindness, New York City
- National Surety Corporation, New York City
- American Red Cross, Niagara Falls Chapter, Niagara Falls
- Metropolitan Life Insurance Nursing Service, Ogdensburg
- Rensselaer County Public Health Organization, Troy
- New York State Department of Health, Utica District, Utica

NORTH CAROLINA

- *Metropolitan Life Insurance Visiting Nurse Service, Burlington
- Catawba County Health Department, Hickory
- Metropolitan Life Insurance Nursing Service, High Point
- Metropolitan Life Insurance Nursing Service, Raleigh

*Agencies on the Honor Roll five years or more.

NORTH DAKOTA

- *Cass County Health Department, Fargo

OHIO

- Alliance Chapter of the American Red Cross, Alliance
- *Barberton Red Cross Nursing Service, Barberton
- Visiting Nurse Association, Branch No. 4, Cleveland
- Visiting Nurse Association, Branch No. 7, Cleveland
- Metropolitan Life Insurance Nursing Service, Elyria
- *Metropolitan Life Insurance Nursing Service, East Liverpool
- *Kent Red Cross Visiting Nurse Association, Kent
- Metropolitan Life Insurance Nursing Service, Lorain
- Metropolitan Life Insurance Nursing Service, Springfield

PENNSYLVANIA

- *Visiting Nurse Service, Allentown
- *North Penn Community Centre, Ambler
- *Community Health and Civic Association, Ardmore
- *Delaware County Tuberculosis Association, Chester
- Hamburg Visiting Nurse Association, Hamburg
- Kutztown Visiting Nurse Association, Kutztown
- *Latrobe Chapter, American Red Cross, Latrobe
- Visiting Nurse Association, Lebanon
- *Lewisburg Community Nurse Association, Lewisburg
- *Morrisville Red Cross Community Nursing Service, Morrisville
- *Mount Pleasant Chapter, American Red Cross, Mount Pleasant
- Montgomery County Tuberculosis and Public Health Society, Norristown
- Northampton Chapter, American Red Cross, Northampton
- *Palmerton School District, Palmerton
- *Henry Phipps Institute, Philadelphia
- *The King's Daughters Society, Pottsville
- Lebanon Valley Visiting Nurse Association, Robesonia
- Pennsylvania Tuberculosis Society, Scranton
- Uniontown Public Schools, Uniontown

RHODE ISLAND

- *Richmond Visiting Nurse Association, Carolina
- Cranston School Health Division, Cranston
- *John Hancock Mutual Life Insurance Nursing Service, Newport
- North Providence School Department, North Providence
- American Red Cross, Tiverton Chapter, North Tiverton
- *Portsmouth Branch, American Red Cross, Portsmouth
- *Visiting Nurse Association of Pawtucket,

Central Falls and Vicinity, Pawtucket
Gorham Manufacturing Company, Providence

Nicholson File Company, Providence

The Texas Company, Providence

*Universal Winding Company, Providence

*Sayles Finishing Plants, Inc., Saylesville

*Warren District Nursing Association,
Warren

SOUTH DAKOTA

Brown County Health Department,
Aberdeen

TEXAS

Central Office—State Board of Health,
Austin

VERMONT

Barre Chapter, American Red Cross,
Barre City

VIRGINIA

*Metropolitan Life Insurance Nursing
Service, Alexandria

Clarke County Public Health Association,
Berryville

Metropolitan Life Insurance Nursing
Service, Danville

American Red Cross, King William
County, West Point

WASHINGTON

*Visiting Nurse Service, Seattle

Pierce County Health Department,
Tacoma

WEST VIRGINIA

Metropolitan Life Insurance Nursing
Service, Martinsburg

WISCONSIN

*Board of Education, Menasha

Superior City Red Cross Nursing Service,
Superior

Bayfield County Nursing Service, Wash-
burn

WYOMING

Park County Public Health Nursing
Service, Cody

WITH THE STAFF

Dorothy Deming went to Boston, Mass., where she was a guest at the Silver Jubilee dinner of The New England Industrial Nurses' Association on May 26. On the following day, she was the speaker at their New England breakfast.

Evelyn Davis spoke at the meeting of the Nassau County Public Health Nursing Council in Mineola, N.Y., on May 22.

Virginia Jones finished her field trip in the Middle West by stopping off in

Chicago, Ill., on April 22 to visit the special maternity course for nurses at the Chicago Maternity Center. She also visited the Fulton-Montgomery County Health District of the New York State Department of Health in Amsterdam, N.Y., from May 24-26. On May 1 and 2, she visited the program of study at the Richmond Professional Institute of the College of William and Mary and on the third the program of study at the Medical College of Virginia, both in Richmond, Va.

After the Biennial Convention, Purcelle Peck attended the National Conference of Social Work in Grand Rapids, Mich., from May 27 to June 1, and the annual meeting of the National Tuberculosis Association the week of June 3 in Cleveland, Ohio.

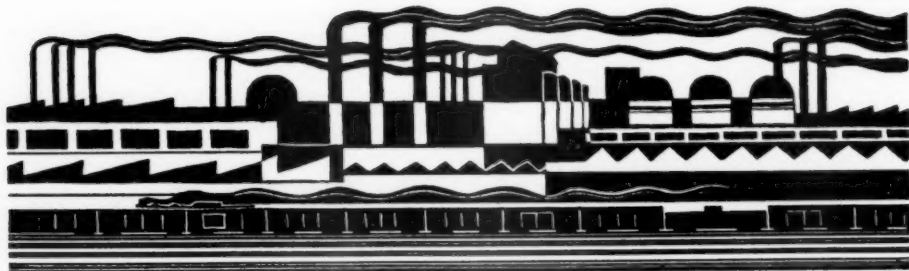
ERRATUM IN LIFE MEMBERSHIP

Emma E. Roberts, director of the Toledo District Nurse Association, should have been given credit as the first life member of the N.O.P.H.N. in the list published in May 1940, page 334. Mrs. S. Emlen Stokes was the second member and Dorothy Deming third.

The Toledo District Nurse Association wrote the N.O.P.H.N. early in 1933 asking if the organization might take out a life membership for Miss Roberts. The following year the membership of the N.O.P.H.N. voted to revise the by-laws, establishing a classification for life members, and Sophie C. Nelson announced that Miss Roberts was the first life member.

The N.O.P.H.N. regrets that due to an earlier method of recording life memberships according to the date of receiving dues, Miss Roberts' name did not appear as the first life member in the complete list published in May. Life members are now numbered according to the date of application.

Hereafter, a list of life members will be published annually.



Home Hygiene Classes in Industry

AS A PART of the health program of our plant, classes in home hygiene and care of the sick have been made available to women employees. Spiegel, Inc., is a Chicago credit mail order house with 5500 employees, of whom 3000 are women. The course was sponsored by the American Red Cross, which contributed the instructor for the classes. The idea was introduced to a group of plant supervisors, department managers, and workers from various departments by the director of classes in the Chicago chapter. The plan was enthusiastically received and the interest of this group soon spread throughout the plant. More than two hundred employees registered for the classes, which were divided into groups of twenty.

Two schedules were offered for the classes, which are two hours in length: twice a week for six weeks or once a

week for twelve weeks. They are held in the assembly room in the plant each afternoon, Monday through Friday, at 4:40 p.m., ten minutes after the end of the working day. The employees prefer this hour because many live far away from their work and there would be much time lost going home and returning for evening classes.

There are milk-vending machines throughout the plant and many employees avail themselves of this service before going to class at the end of the day.

The American Red Cross textbook is used. Two or more employees may purchase a book and use it together. Demonstration materials are furnished by the local Red Cross chapter, and remain at the plant until the course is completed. Many small items such as medicines, wax paper, spoons, and cups to be used for demonstrations are furnished by members of the class. The



Preparing the baby for his bath



Baby's first dip

Red Cross certificate is awarded to those who successfully complete the course.

That the classes meet a real need is evidenced by the interest and response from the employees. One group of employees wrote:

These employees wish to express their gratitude for the fine instruction they received and feel that they have been more than repaid for the time spent in these classes.

Many individual expressions of appreciation were received, of which this one is typical:

I have a chronically ill relative at home and our home hygiene class has been such a help to me. I have learned how to help handle her more easily and I've learned ways to make her more comfortable.

Another employee stated:

It is surprising what little attention we pay to the importance of a well balanced diet. Our home hygiene course has taught us much about proper food. I feel this was a valuable part of the class work.

The class work is much discussed throughout the plant. The men employees have asked us:



Bedside care of patient

When are you going to give classes in hygiene to the men? Men need to and can learn about their health and hygiene the same as women.

Although it would be impossible for a full-time industrial nurse to carry a heavy schedule of classes, she could well afford to devote the time to one or two classes a week. This would give her the valuable opportunity of becoming better acquainted with employees and of teaching positive health to groups instead of limiting this instruction to the individuals she meets in her daily contacts.

GLADYS A. JAHNCKE, R.N.
Spiegel, Inc., Chicago, Illinois

CONTROL OF SYPHILIS IN INDUSTRY

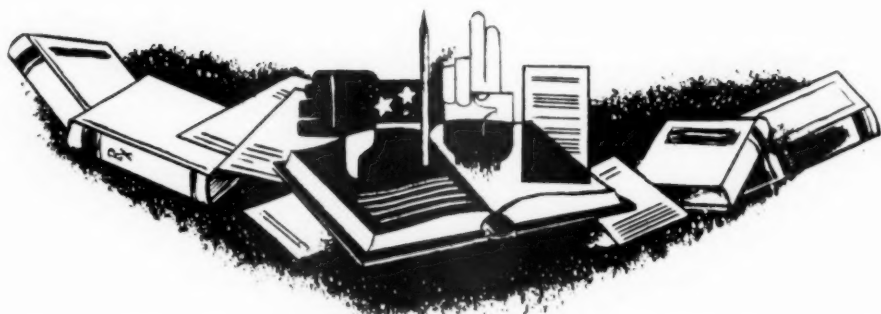
SHOULD every industrial worker have a blood test for syphilis or only those in whom syphilis is suspected? Why is syphilis control in industry important? How do industrial workers with syphilis usually secure treatment? These and other important questions are discussed in an important article, "Syphilis Case-Finding in Industry," by Dr. Albert E. Russell in *The Journal of the American Medical Association*, April 6, 1940, page 1321. Dr. Russell, who is surgeon in charge, syphilis control in industry, United States Public Health Service, outlines the cooperative control of syphilis in industry recommended by the Surgeon General and makes a preliminary report on the case-finding proj-

ects sponsored by the Service in cooperation with industries and state and local health departments.

He cites the impressive fact that a syphilis control program reaching the 15 million people employed in the mining, mechanical, and metal trades, and their families, will include about half the population of the United States.

Dr. Russell quotes data presented by the American Social Hygiene Society showing that "in the course of physical examinations where blood tests were made only when syphilis was suspected, 0.6 (six-tenths, or less than one) case was found per thousand compared with 44 in 1000 when routine blood tests were made."

Industrial Nurse: See also pages 363, 406, and 407.



EDITED BY ANNA C. GRING

THE WAY LIFE BEGINS

By Bertha C. Cady and Vernon M. Cady. 80 pp. American Social Hygiene Association, New York, revised 1939. 50 cents.

This book is meant to be used by parents and teachers as an introduction to the question of sex education. It presents in a very scientific yet understandable way the reproductive processes of nature as evidenced in certain species of the plant and animal kingdoms. Each example is beautifully illustrated with a plate and figure, some of which are in color.

The last ten pages are given over to the reproductive processes of the human being, with two figures, one of the male and one of the female.

The authors feel very strongly that such knowledge on the part of adults is very necessary if they are to avoid the embarrassment which too often leads to a cold and impersonal silence and if they are to dispel much of the mystery which surrounds the subject of reproduction and the function of the sex instinct in the whole fabric of life. In its place, should come a knowledge and an understanding of self which will bring about "an equilibrium between the torrent of impulse within and the many outward barriers which civilization has raised against what it considers the improper expressions of sex."

SABINA H. REAGAN
Moorestown, New Jersey

CIVIL SERVICE IN PUBLIC WELFARE

By Alice Campbell Klein. 444 pp. Russell Sage Foundation, New York, 1940. \$2.25.

Public welfare, that ubiquitous word covering so many fields of work being done by so many professions, has found itself greatly in need of an authoritative reference on civil service procedure. This need arose from the sudden expansion of assistance programs under public auspices and particularly from the regulation of the Social Security Board that all personnel operating under the Act must be merit system employees.

Civil service has been a casual friend to the professions of nursing and social work, but now it is married into the family and we must know it intimately in order to have a productive relationship. Alice Klein introduces us to the complexities of the system by exploring the early life history of this suddenly expanding field, and describing the forces that were at play during the developmental period of its lusty and vigorous growth. We learn to know what the major problems are and why they exist; what, in general, are the procedures. Explorations are made into the various selection processes, including the scoring and grading of the written and oral examinations. Among other problems, service ratings, recruitment, probation periods, and staff development are treated.

In the second half of the book, the

author ties together the field of social work and civil service in a very real and helpful way. In this she has had experience, having worked in Pennsylvania during the upheaval of 1937 when all employees in the public relief agencies were put through the newly provided merit system mill. Being an innovating and realistic person, she gives sound suggestions to both sides as to what each needs to know and appreciate in the other to work effectively together.

While the book is a thorough and competent study of the subject, the reader does not feel heckled by too many footnotes and appendix references, and the author has made a large and complicated subject not in the least ponderous or pedantic. The bibliography on civil service is arranged in an especially useful and interesting way.

There are few persons in the professions who have not had some personal contact with civil service procedures. To that group who probably seek specific help and to all of those who want more than a speaking acquaintance with merit systems, the reading of this book is the answer.

MRS. FLORENCE BOOTH
Detroit, Michigan

MENTAL HEALTH

Publication of the American Association for the Advancement of Science. 470 pp. The Science Press, Lancaster, Pennsylvania, 1939. \$3.50.

Many of the points emphasized in these reports should help the nurse to see the value of psychiatry in general medical practice. The book contains the full reports of the Symposium on Mental Health held by the American Association for the Advancement of Science in collaboration with the American Psychiatric Association and with the coöperation of the United States Public Health Service, the National Committee for Mental Hygiene, and the Mental Hospital Survey Committee.

The reports are written by leaders in

the mental hygiene field and are grouped under the following seven sectional headings: (1) Orientation and Methods in Psychiatric Research (2) Sources of Mental Disease: Their Amelioration and Prevention (3) The Economic Aspects of Mental Health (4) Physical and Cultural Environment in Relation to the Conservation of Mental Health (5) Mental Health Administration (6) Professional and Technical Education in Relation to Mental Health (7) Human Needs and Social Resources. At the end of each section there are formal and informal discussions regarding the papers presented and in several instances a selected bibliography.

Many of the papers stress the need for the physician to have a working knowledge of psychiatry in order adequately to diagnose and treat his patients. Dr. Franklin G. Ebaugh points out that a "knowledge of emotional turmoil, feelings of inadequacy, frustration, disappointment, unresolved conflicts, guilt feelings, and lack of satisfying experiences is just as important in diagnostic and therapeutic procedures as a knowledge of pain, temperature, induration, breath sounds, or evidence of decompensation." Dr. Flanders Dunbar asks, "What do we pay for disregard of the psychic component in illness?" Her discussion on accidents should prove especially helpful to the industrial nurse and visiting nurse.

The papers in the section on sources of mental disease, heredity and eugenics, the relationship of certain exogenous agents—such as syphilis, alcohol, and vitamin deficiency—to the psychosis, and the role of social circumstances such as immigration and the broken home in psychiatric situations, are excellent.

The two papers on nursing, *The Present Status of Psychiatric Nursing in the United States and Canada*, by G. H. Stevenson, and *The Public Health Nurse in Potential Relation to Mental Health*, by Sybil Pease, and the informal discus-

sion on these papers by May Kennedy should be interesting and helpful to every nurse.

This book should prove an excellent reference for acquainting the nurse with the latest thinking in the mental health field.

RUTH PEARL, R.N.
Brooklyn, New York

COMMUNICABLE DISEASES

By A. M. Stimson, M.D. 111 pp. Miscellaneous Publication No. 30, United States Public Health Service. Superintendent of Documents, Washington, D. C., 1939. 25 cents.

This handbook presents current information about the so-called communicable diseases which are thought to be most important for the people living in America. A comprehensive glossary and suggestions for utilizing the material enhance the value of the book, which is an excellent reference book for teachers and nurses.

A. C. G.

AMERICAN STANDARD SAFETY CODE FOR THE PROTECTION OF HEADS, EYES, AND RESPIRATORY ORGANS

National Bureau of Standards Handbook H24. 95 pp. United States Department of Commerce, Government Printing Office, Washington, D. C., 1938. 15 cents.

Nurses in industries where a safety engineer is not employed will find this handbook an invaluable reference on industrial hazards and the necessary safety standards and devices. While there are many technicalities beyond the scope of the nurse, such as determining the existence and extent of hazards, developing appropriate safety standards, and selecting the proper safety devices or equipment, she should be familiar with such an authoritative guide as this and able to refer the proper personnel to it. This book will also help the nurse to be more aware of the types of hazards commonly found in particular activities in any industry, and through greater familiarity with types of safety devices

to note the presence or absence of the appropriate equipment to protect the heads, eyes, and respiratory organs of the workers. Through the study of this book the nurse will see many opportunities not only to stimulate the provision of adequate protection but to encourage its proper use.

ELEANOR W. MUMFORD, R.N.
New York, New York

HIGH SCHOOLS AND SEX EDUCATION

By Benjamin C. Gruenberg, with the assistance of J. L. Kaukoren. 110 pp. U. S. Public Health Service, Bulletin No. 75, revised. U. S. Government Printing Office, Washington, D. C., 1939. 20c.

This manual is based on a book of the same title published by the United States Public Health Service and the United States Office of Education in 1922. Acknowledgment is given to a representative advisory board who assisted in the preparation of this publication.

It represents an effort to remove sex education from a logic-tight compartment apart from living to the recognition that sex is as much a part of living as eating or sleeping. It is intended primarily for teachers in the secondary school. Realizing that some teachers are more competent to deal with their pupils than others, the handbook brings together the observations and experiences of one group of teachers to aid the other group. The manual includes a discussion of the reasons for and the place of sex education in the secondary schools, the qualifications of the teacher, and specific suggestions for the correlation of sex education with the many subjects in the curriculum. Reading lists for teachers, school officials, and students; pamphlets and visual aids; and a suggested outline of a course for teachers on sex education in the secondary schools are included in the appendices.

The book should be very helpful to teachers and school officials, especially if due recognition is given to the fact

that a sound emotional outlook is probably of greater importance than the teacher's intellectual resources.

A. C. G.

PEDIATRICS AND PEDIATRIC NURSING

By A. Graeme Mitchell, M.D., Echo K. Upham, R.N., Elgie M. Wallinger, R.N. 575 pp. W. B. Saunders Company, Philadelphia, 1939. \$3.

The authors of this book have succeeded in combining in a remarkable way a description of the growth and development of the normal child, a textbook on pediatric diseases, and a manual of nursing techniques.

The method in which the material is presented makes it especially useful as a reference book, since the index is complete and adequate. The material is therefore available by easy reference for anyone wishing to gain information concerning a particular phase of child care. The introduction of questions at the end of each chapter makes it a suitable textbook for classroom work.

The reputation of the medical author in the field of pediatrics is convincing

evidence of the accuracy of the information contained and the authoritative nature of the opinions expressed.

The printing is clear and the paper is good, so that reading is easy.

One can recommend the book unhesitatingly as a valuable addition to any library for nurses. It should serve a useful purpose as a book of reference and study for nurses in schools of nursing and for graduate nurses in private practice, institutional work, or public health nursing.

RICHARD M. SMITH, M.D.
Boston, Massachusetts

MANUAL FOR FLORIDA STATE-WIDE PUBLIC HEALTH COMMITTEE

By Jean Henderson, 170 pp. State-Wide Public Health Committee, Jacksonville, Florida, 1940. \$1.

This manual for the development of local lay committees was prepared by the executive secretary of the Florida State-wide Public Health Committees. It contains material that will be useful to other citizen committees.

RECENT PUBLICATIONS AND CURRENT PERIODICALS

INDUSTRIAL NURSING

The Journal of the American Medical Association, February 17, 1940.

This number, entirely devoted to industrial health, contains many articles of interest to the industrial nurse. "A General Statement of Medical Relationships in Industry Presented by the Council on Industrial Health of the American Medical Association" (p. 573) is especially valuable as showing the scope of an industrial health program and the needs in this field.

AN INDUSTRIAL DEPARTMENT OF HEALTH. 56 pp. Bulletin No. 9, Department of Industrial Medicine, Northwestern University Medical School, Chicago. 1939. \$2.

A brief collection of practical information concerning medical personnel, dispensary arrangement, space, equipment, physical exam-

inations, industrial health surveys, and social insurance laws.

Industrial Medicine, March 1940.

Attention is called to three articles in this issue. "Health Problems of Workers" by R. R. Sayers, M.D., and J. J. Bloomfield (page 12) outlines the kind of information needed to determine the extent and kinds of ill health among workers and the types of service needed to conserve the health of workers. "Tuberculosis Case-Finding" by Leopold Brahdy, M.D. (page 139) discusses some of the problems in making a diagnosis of tuberculosis. "Employee Health" (page 164) is an analysis of the impact of employee health on industrial relations.

INDUSTRIAL HYGIENE—RETROSPECT AND PROSPECT. J. J. Bloomfield. *American Journal of Public Health*, November 1939, p. 1215.

A discussion of accomplishments in industrial hygiene and some of the problems.

NEWS NOTES

- The Western Branch of the American Public Health Association will hold its eleventh annual meeting in Denver, Colorado, June 23-27. The program will be devoted to a discussion of public health matters of special interest to the West, and will present speakers of national and Western prominence. Inquiries should be addressed to Dr. A. L. Beaghtler, director of health service, Denver Public Schools, Denver, Colo., or to W. Ford Higby, secretary, Western Branch, American Public Health Association, 45 Second Street, San Francisco, Calif.

- Elizabeth Curtis has been appointed as state advisory public health nurse in the New Jersey State Department of Health. Miss Curtis received her certificate in public health nursing from the University of Minnesota and her master's degree in public health nursing from Teachers College, Columbia University.

- The Maternity Center Association in cooperation with the Department of Nursing Education of Teachers College, Columbia University, announces a two-months' program of advanced maternity nursing, September 23 through November 22, for a limited number of maternity supervisors in the field of public health nursing.

The program will include lectures on obstetrics, community maternity nursing, educating the public, and other subjects affecting the care of maternity patients; supervised observation; round-table discussion of administrative and other problems; assigned reading; and study hours.

To register write directly to the Maternity Center Association, 654

Madison Avenue, New York, N.Y., giving your name, address, and position held. Registration will be closed on September 9 or sooner if sufficient students register. Students wishing to matriculate or matriculated in the Department of Nursing Education at Teachers College should indicate upon application if they wish to work for credit. The unit counts six points credit and the regular college tuition fees will be charged. Students not applying for credit will be charged a registration fee of \$50. It is possible to keep living expenses within \$75 a month. Registrants will be sent a list of several places where they may secure rooms at reasonable rates.

This unit is not to be confused with the four-months' unit in advanced maternity nursing offered each February at Teachers College in cooperation with the Maternity Center Association.

- The annual conference of the New England Health Education Association will be held on June 7 and 8, at the Massachusetts Institute of Technology, Cambridge, Mass.

- The American Red Cross held its annual convention in Washington, D.C., May 6-8. There was a total registration of 3750, which was 700 more than the previous record attendance in 1938 in San Francisco. There were 130 nurses from thirty states and the District of Columbia registered.

- The American Dietetic Association will hold its twenty-third annual convention at the Pennsylvania Hotel, New York, N.Y., October 10-24, 1940.

PUBLIC HEALTH NURSING

Official Organ of the National Organization for Public Health Nursing, Inc.

Democracy at the Crossroads

WITH SUNNY skies overhead but the foreboding cloud of the European War heavy on the hearts of all, the 1940 Biennial Convention opened in Philadelphia on May 12. As all of man's progress toward democracy seemed threatened with extinction, 7500 nurses and citizens interested in nursing gathered to consider the subject of "The Nurse in a Democracy." It was an appropriate theme. Not only in the great general meetings but over dinner tables and in group discussions the question recurred: Shall we be able to save our democracy? And inevitably the corollary followed: Are we building a democracy in truth as well as in name, with economic and educational opportunity for all, with an inner strength born of the confidence that it has used all its resources to provide a good life for its people?

Perhaps the most hopeful sign was the willingness to face the fact of our failures. The challenge presented by our inability, so far, to provide economic security and health through the processes of democracy was the keynote of the joint opening session on Monday night. Quoting from the studies of the National Resources Committee, Dr. Mildred Fairchild of Bryn Mawr College emphasized the fact that health and security remain an unrealized dream while a third of our people have an annual family income of less than \$800, and the median income of the American family is approximately \$1100 a year; while we are unable to develop the social organization which will make adequate health service available for all. Summarizing

the findings of social research in terms of human need she defined the problem faced by democracy in adapting an economy of plenty to meet the needs of all.

The same emphasis on the interrelationship between health and economic and social problems was made by Kenneth L. M. Pray of the Pennsylvania School of Social Work at the opening general session of the N.O.P.H.N. Mr. Pray charged the professional worker with the obligation of interpreting to the community the inescapable fact that health is a social responsibility. He found encouragement in the fact that never before has a period of social disorganization "been analyzed and measured with anything like the same intensiveness and accuracy that has characterized the social research of the last decade." Reminding his hearers that inadequate wages, working conditions, and living conditions produce health problems faster than they can be solved, he challenged: "Can we be satisfied, as professional people, with the perpetuation of conditions that inevitably limit the values of our own professional performance?"

The public health nurse perhaps more than any other individual is acutely aware of the physical hazards and social degradation inherent in ramshackle and congested housing conditions—whether in tenement or shack-town. Democracy's efforts to provide decent homes for its citizens through modern government housing projects was described by Dr. C.-E. A. Winslow in an address to almost a thousand people at the

N.O.P.H.N. board members' dinner in the ballroom of the Bellevue-Stratford Hotel.

The need for community planning as a democratic method of social betterment to replace separate and often conflicting efforts was echoed in various meetings. A practical application of such planning through local health councils and committees was discussed by Dr. Ira V. Hiscock of Yale University. The theme of community coordination recurred in the panel on the school child, in which there was a lively exchange of ideas between ten participants representing community social and health agencies, physicians, the school administration, and the school medical and nursing service.

The philosophy underlying the democratic way of life and its practical application to our profession, particularly in critical times such as this, permeated many of the discussions. It was the central theme of the N.O.P.H.N. general session on "Leadership Through Supervision"; in the League panel on the question: Does nursing education prepare a nurse for life in a democracy; and in the joint session on "The Preparation of the Nurse for Leadership in a Democracy." The philosophy or the "working faith" underlying nursing in these times of violent social upheaval in the world was analyzed by Dr. Alan Gregg, director for the medical sciences of the Rockefeller Foundation, in a stirring address which was one of the high spots of the convention.

The practical problems facing us day by day in our work were by no means ignored. Ideals, goals, a better way of life for our people are achieved only by the hard work of the professional and lay person, jointly carrying on their tasks with courage and faithful effort. Nutrition, to which an entire N.O.P.H.N. general session was de-

voted; the health of the worker in industry, of the child in school and at camp, of the college student, of the mother at delivery, of the newborn infant; the administrative details that make the wheels go round, such as the training and selection of qualified professional workers, publicity, sources of income, analyses of costs—all of these were discussed in papers and round tables and the two-day group conferences preceding the convention.

The indefatigable interest of nurses in professional growth—in giving the best that is in them to the patient and family and community they serve—and their essential unity of purpose have never been more evident than in the convention meetings. This unity was symbolized in the final scene of *The American Journal of Nursing's* beautiful historical pageant, where the health of the family was depicted as the goal of all nursing.

What, then, do we need most to hold onto in the unpredictable road that lies ahead in this time of world crisis? Is it not that we as nurses must hold steadily to those goals of social betterment which we believe are fundamental to a democracy that can survive? That we shall stand courageously for the things we believe in and strive for tolerance and understanding of those whose experiences have given them a point of view different from our own? That above all we shall interpret social needs as we find them, to the people in our communities who have the power to effect those social changes that will prevent the problems with which we cope? For, to quote Dr. Fairchild "The defense of democracy . . . lies not merely in the show of force that some of us can muster; it is equally and eventually, in our ability to meet for our own people the very issues that have given rise to dictatorships abroad."

P.P.

NATIONAL ORGANIZATION for PUBLIC HEALTH NURSING

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Term Expires 1944

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 W. Frank Walker, Dr.P.H., New York, N. Y.
 Abel Wolman, Baltimore, Md.

Nominating Committee 1940-1942

Raymond F. Clapp, Indianapolis, Ind.
 Katharine Faville, R.N., New York, N. Y.
 Anna Heisler, R.N., San Francisco, Calif.
 Marguerite Wales, R.N., Battle Creek, Mich.
 Estella Ford Warner, M.D., Albuquerque, N. Mex.

The revisions in the N.O.P.H.N. bylaws were accepted as sent to the membership.

Nursing in Our Times

By ALAN GREGG, M.D.

**"An independent estimate of nursing in our times,"
presented at the American Red Cross joint session
of the Biennial Nursing Convention in Philadelphia**

PLEASE let me dispense with prefaces and introductory anecdotes, with elaborate excuses or disarming disavowals, and offer an independent estimate of nursing in our times. That subject, like a good wine, needs no bush.

Nursing in our times? These are times of war—war in the continent to the west, war in the continent to the east, and, even to the north, for our nearest neighbor and closest friend, the anxieties and hazards of war. In terms of time we are in war; only in terms of space and feeling are we at peace. I was in France and England three months ago and you must excuse me if I find our times no occasion for a speech composed of felicitous phrases and happy compliments. Emotions there are too deep for tears and impending changes too serious for casual description. I know you will pardon me if you understand the cause for utter seriousness in what I have to say.

It is not merely that there is war on land, sea, and in the air. It is not merely the waste, the wreckage, the weariness, the wounds, and the deaths of those who bear arms. It is the almost universal change in the feelings and the manner of thought of millions—of hundreds of millions—of children, of women, and of men. For in order to kill your fellowman you must first work yourself into believing that he is inhuman and then you can hate him and fear him and kill him with a sensation of duty and righteousness. Calling

names, pushing the branding iron about, howling abuse, repeating incantations, baying with the pack—it reminds me that Booker T. Washington said that if the Negro is to be kept down, some white men will have to stay in the gutter to keep him there. Our times are times of envy, cynicism, anxiety, suspicion, fear, and hatred, uncertainty and foreboding—the contagious breakdown of decency in human relations. I imply no superiority; it is too big and inescapable. There, but for the grace of God, go we.

WHAT REALLY MATTERS TO US?

What can we do, what can you as nurses do, as witnesses to such disasters? It would seem certain that we should seek more honestly and more earnestly than ever before to find what really matters to us, what beliefs and convictions we have and hold.

As has been wisely said: "When you break the little laws, the big laws begin to operate." What bigger laws are there than the little laws of lawyers and governments so generally tottering or collapsed? It is a simple matter of fact that for those who value life the laws of human kindness are greater than the laws of fear or hate because from charity comes life continuing, whereas hate leads to death. Buddha remarked that anger is like spitting against the wind—it just comes back all over you. What is that wind that blows back upon man himself the product of his rage? I would

hold that it is the operation of one of the bigger laws—a current more enduring and resistless than death. When envy and malice and hate and violence have exhausted themselves, it will be magnanimity that will sustain the world and revive the decency of human life. This I take to be the conviction of the Red Cross, and the working faith of nurses regardless of the obstacles, discouragements, and challenges you encounter.

NEED FOR A WORKING FAITH

Some may sneer that such fine sentiments are all very well, but are hopeless, visionary, and futile. I can only bear witness to my own experience of this world—that when men cease trying to be decent and kind, visions give place to nightmares and hope turns into foreboding. And as for futility, could anything be more futile than the nature of war? With man's present mastery over nature, with his wizard's control over sources of physical power, he will be, unless he also learns the practical value of fine sentiments, like an infant playing with a revolver, or a five-year-old exultant at the wheel of a motor truck on a speedway.

So in these times of doubt and pessimism as to which laws will last the longest, those of hate or love, it is important to find on what we may completely rely; to examine the articles of the nursing faith. These articles I hold to be but two—a way of meeting evil, and self-confidence. My title was "An Independent Estimate of Nursing in Our Times." No estimate of mine could matter much. It is you who must have an independent estimate of nursing in our times—nothing else can concern you more, nothing else could strengthen you so abundantly, or sustain you more steadily in hours of weariness and discouragement and loneliness.

A WAY OF MEETING EVIL

The way of meeting evil things and evil people is to realize that evil comes

about by processes and from causes as natural and impersonal as those that maintain the right. The conduct of a madman is not the intention of an indwelling evil spirit; it is the result of an invading microorganism, or the poisoning of alcohol, or defective blood supply, or some similar natural cause. The aggression of a delinquent boy derives naturally from the accumulated frustrations of loveless childhood. The rain that ruins a church bazaar is the result of wind and temperature, not of a vindictive demon. As Lincoln Steffens used to say, "Don't ask who did it—ask what did it." It is not from demonology but from physiology that medicine has accumulated that knowledge which is power over disease and suffering. David Cecil said recently, "Barbarism is not behind us—it is beneath us." We have not and we cannot bid Mid-Victorian adieu to all the animal in man in the assumption that evolution has progressed so far that our generation has no need of unremitting effort to be wise and sane. Progress and evolution in the social wisdom of man do not derive from chemistry and physics and mechanical skill. As Artemus Ward remarked: "Ain't it a funny thing that men that are clever enough to build the Brooklyn bridge, ain't clever enough to keep condemned wire from being put into it!" Decency does not visit our common dwelling place without invitation, nor does she remain without imagination to welcome her, and thoughtful hospitality to bid her stay.

SEEK NATURAL CAUSES OF EVIL

Nor does the equanimity of this way of meeting evil rest merely there. Only when we seek the impersonal natural causes of evil shall we learn what to anticipate, what to remove, what to correct, and thus how to control and prevent those results which are called evil. Otherwise they are inescapable but always natural.

Think of that old man you took care of when you were a probationer. He was a cardiac with orthopnea. His nights were evil to him. If sleep finally came, his dreams were anguished. His waking hours were pathetic, harried. There was no evil intention anywhere but a natural operating cause—a heart unequal to its work unaided. The leaves of the fox glove, a cleverly arranged bed, a restriction of the fluid load upon his heart—all impersonal measures, anticipations, reliefs, and corrections—and you had met the evil of his illness. He thought the symptoms mean and evil. You thought of them as natural and removable. The fact is they were removable because you found them natural and impersonal.

Surely your days of triumphant care and cure have rested on this attitude toward evil. Not who or why, but how and by what natural processes has an evil thing befallen. That is what I mean by the way of meeting evil. It is the essential assumption behind effective medical research. It is the first choice of methods to solve unhappy personal relations, to postpone our responses until we can see what entirely normal and impersonal factors brought the situation about. It is in clearest, loveliest contrast to the neurotic assumption that in some fashion you are being attacked or threatened by a human enemy or a malevolent Nature. "All criticism is a form of autobiography," said a shrewd observer. To regard human conduct or natural phenomena as the evidence of inescapable malice is to record our own neurotic fears without explaining anything, or helping at all.

Now this does not mean published denial or disregard of evil. Cruelty, malice, pus, and insanity exist, God knows, but they can be met with equanimity as being in origin impersonal and natural, and thus preventable and controllable. By so much as you can meet evil in this wise, living becomes delight-

ful, fearless, and rich with understanding, unembittered by self-pity and free for the exercise of comprehending kindness.

MATURE SELF-CONFIDENCE NEEDED

But now I come to a harder task, the second article of a nurse's faith—self-confidence. And so I venture to discuss it, but in my reluctance to fail in this attempt I think of a recruit to the air force at Kelly field. He had done well in all the new tasks and drills he had been given, until it came to practice at parachute jumping. At this he refused absolutely and categorically—indeed so vehemently and explicitly that he was brought before an officer for reprimand. The officer said, "You have done well thus far, you've been a good soldier up till now. And now why in the world do you balk at parachute practice?" The soldier replied, "I don't want to practice anything I've got to be perfect at the first time!" I feel for that man's hesitation.

Nonetheless I'll take the unnatural leap, bidding nervous adieu to surer subjects, and with a desperate eagerness to succeed I shall throw myself upon your invisible indulgence and venture to discuss the importance of your having self-confidence. The first moments will be the worst. Not until the theme is fully unfolded can I hope to feel sustained.

NOT MERELY SELF-ASSURANCE

Self-confidence is not to be confused with the cheery assurance that comes from easy approval of friends, or the naive grace of childhood. It is an adult characteristic because mankind is too strongly social in his instincts and emotions to be able continuously to override the opinions of others and maintain self-confidence in the face of general disregard. Yet in St. Paul's Church in Richmond on the memorial to Robert E. Lee is the text from the Bible, "By faith Moses refused to be called the son of

Pharoah's daughter, choosing rather to suffer affliction with the children of God." That is a testimony to Lee's self-confident faith and unswerving loyalty to his own.

As adults are more mature than children, so heroes are more mature than adults and especially in this matter of self-confidence. Do not confuse self-confidence with self-assurance or self-esteem. Lee was confident of where his duty lay. He regarded himself as the instrument of a cause he could not and would not fail. The self-assured man breaks down when the self-confident is still convinced—and convincing. It has been my experience that the real people in this world are those to whom the world is real, and their participation in it. Self-confidence is the determination to participate in a very real world.

MORALITY OR VIRTUE

Too few of us reflect upon the difference between the Roman idea of morality and the Greek concept of virtue. Morality was a social concept, a basis for outward conduct, an adherence to what was accepted by one's fellows, a following of traditional mores and customary usages. Virtue, on the other hand, had a different meaning. It is of the inner life as well as the outer, a harmony and consistency of behavior with one's own thoughts and feelings.

It is possible then to have virtue and yet not be moral, and to be moral without being virtuous. And this is significant for those whose convictions are at variance with prevailing moral standards and values. If, though you know cheating to be senseless and cowardly, you cheat in a world where cheating is the rule, you are moral but you are not virtuous. If, though everybody else sets and follows the standard of underpaying their employees, you refuse to do so, you are virtuous, but you are not moral. Indeed you may so seriously offend the standards of the community

in this regard that you will receive moral pressure to mend your ways and "get in line." Or let us put it all in a sphere where we are still in the stage of creating an ethic of behavior. If everybody else goes at 60 miles an hour and believes it "all right" to do so, and you believe it foolish and dangerous but you give in, you are being moral but not virtuous (you know that uneasy feeling!). If you keep down to forty you'll be virtuous but not moral. Virtuous living, I need hardly say, offers plenty of scope for rugged American individualism, even more opportunities than quarreling with the government. As between the virtuous and the moral, the merely virtuous are less likely to be popular, and the merely moral less likely to have the respect of their intimates—or of themselves.

NURSING IN A COMPETITIVE SOCIETY

The thing that is in play then is: to what extent does the individual reflect upon his environment, decide to accept its standards or deliberately reject them? You nurses are living in a strongly competitive society. What has nursing to do with the survival of the fittest? Do you accept that or reject it? The values of the competitive life are so entrenched about us that it takes courage to question the merits even of senseless competition. How much approval or sanction do you expect for your salvaging human bodies and minds, from the relentlessness of those who ignore the theory of mutual aid of Kropotkin and prefer to quote heartily Darwin's survival of the fittest? The virtue of nursing can very wisely disregard the morality of a purely competitive environment, and your self-confidence need not be shaken by the disdain of those who rely upon competition to measure your success.

You are nurses living too in a society dominated by rather remarkable extensions of the idea of private property.

Thanks to the long connection between Christianity and medicine we are encouraged to attend to the poor. And since so often illness follows long poverty and poverty follows long illness, we nurses and doctors can follow, and indeed, to be inwardly consistent in our lives, we must follow a course that is outside the chilly orbit of private property. Can we lose our self-confidence because the rich do not do as we do?

Another item of your environment to examine. You nurses live in a time and in a society which attributes weakness to woman. The long struggle for women's rights as holders of property, as voters, indeed as persons, would not have taken place had the mores and usages and attitudes of our society been those of assuming innate and matter-of-fact equality between men and women. In my opinion much remains to be done before these all-pervading imputations of inequality are removed. In the meantime can you expect reassurance from a society so obviously competitive, acquisitive, and adolescent?

No, I like better Lowes Dickinson's attitude, that only a person who is something to herself can become anything to anybody else. The values which sustain you in your profession are at variance with many of the values esteemed by mankind nowadays — competitive success, money, masculine superiority. Quite simply said, your faith in nursing must come not from such morals but from within, from reflection, deliberately.

MUST BE SURE OF MOTIVES

Lest such reflection be no better than self-pity, it is clear that to maintain self-confidence and independence you must above all be sure of your motives. For unless conduct harmonize with motives and motives themselves be sound and consistent, there can be no virtue in the Greek sense, no independence, and no self-confidence. Generosity as a mo-

tive for nursing is not enough. Indeed it is the too common failing of generous people that they are selfish in their generousities, insistent on thanks, gluttons for gratitude. A craving for dependents is not enough; it is too often a disguised passion for power and possessiveness. And as Tagore observes, "It is only when we get to the point of letting the bird out of the cage that we can realize how free the bird has set us." "Patriotism is not enough," as Edith Cavell courageously observed. I shall never forget the sight of a nurse in a casualty clearing station coolly knitting by lantern light while some eight German soldiers in her care gasped to her indifference for water to slake the thirst of hemorrhage from their wounds.

Mere curiosity and a love of the dramatic are not enough. They wilt before the drudgery and resent the repetitious obligations of uneventful days. Mere economic necessity is not enough; the sick require more than wages alone can buy. Nor is the holy zeal of the obsessive a wise motive in any profession. You know those holy terrors. Kipling says somewhere, "The most terrible thing in the world is a band of ruffians led by an aristocrat. Nay, there is one more terrible, a band of Scotch Presbyterians arising from their knees to do the will of God." And even Cromwell had need to curb his fanatical followers when he said: "Gentlemen, I beseech you by the bowels of Christ just to consider for one moment that you may be wrong." These people, these obsessive people, forever in a state of tension and crisis, who approach every human contact with theories and anxiety, who never will take folks as they are, who want the world to move out of their way, embittered, obsessed with a single theory, whose idea of conversation is an inventory of their grievances! No common sense, no easy give and take. Surely such obsessive passion is not an adequate motive for the life of a nurse. No,

the soundest motive for the nurse is the steady desire to be useful in sustaining life and hope. With this motive you can be consistent in feeling and in action, and with cheerful equanimity, self-confident.

But it will not be so easy. New factors affect our lives these days. We must meet new conditions, the latest of which in human history is prosperity. Let me explain. Thirty years ago in a lecture at college Professor T. N. Carver said to us something like this:

The history of mankind could be written in terms of the survival of adversity—adversity in three principal forms: famine, epidemic disease, and war. Now the discoveries of the nineteenth century have vastly influenced two of these factors. War still remains, but the telegraph, the steamship, and the railroad have enormously reduced the chance of famine, and the progress of medicine has reduced epidemics to almost negligible proportions.

And then, looking out over the class, he added:

I suspect that some of you young men will witness the beginning of a struggle for survival not of adversity, but on a basis for which the human race is by experience and tradition but poorly prepared—namely, who will survive prosperity?

That is a warning distinctly worth remembering.

WHO WILL SURVIVE PROSPERITY?

One of the tricks prosperity plays upon us is that it makes it so hard to appreciate what we have never been without. Prosperity anesthetizes eternal vigilance. A friend of mine had to experience illness in a primitive civilization before he could exclaim: "I always knew the great difference between a good nurse and a poor nurse, but I never knew before the huge difference between even a poor nurse and no nurse at all." Prosperity is too inclined to finger life's pages with a listless hand asking if civilization, after all, is worth it. The answer, if prosperity is all there is to civili-

zation, is clear. That question always reminds me of the observation about being in love. "Being in love is like an egg: if there's any doubt about it there's no doubt about it." Don't let prosperity hide from you what adversity would reveal—the value of your capacities and the usefulness of your profession.

Even so it is not easy to maintain against the attrition of daily living a deep and abiding confidence in one's self. I have never seen it better expressed than in an address Justice Holmes gave to young men more than forty years ago:

Your education begins when what is called your education is over—you . . . have begun yourselves to work upon the raw material for results which you do not see, cannot predict, and which may be long in coming—when you take the fact which life offers you for your appointed task. No man has earned the right to intellectual ambition until he has learned to lay his course by a star which he has never seen—to dig by the divining rod for springs which he may never reach.

In saying this, I point to that which will make your study heroic. For I say to you in all sadness of conviction, that to think great thoughts you must be heroes as well as idealists. Only when you have worked alone—when you have felt around you a black gulf of solitude more isolating than that which surrounds the dying man, and in hope and in despair have trusted to your own unshaken will—then only will you have achieved. Thus only can you gain the secret isolated joy of the thinker, who knows that, a hundred years after he is dead and forgotten, men who never heard of him will be moving to the measure of his thought—the subtle rapture of a postponed power, which the world knows not because it has no external trappings, but which to his prophetic vision is more real than that which commands an army. And if this joy should not be yours, still it is only thus that you can know that you have done what it lay in you to do—can say that you have lived and be ready for the end.*

ENDURING STRENGTHS OF NURSING

Let us consider this inventory of the circumstances which affect your confi-

*Holmes, Oliver Wendell. Speeches by Oliver Wendell Holmes. Little, Brown and Company, Boston, 1913.

dence in yourselves as now complete. You know better than I the difficulties, but at least I know they are more than I have listed. May I now venture to mention some of the natural advantages, the certain strengths of nursing, the enduring conquests of your calling.

Principal among the triumphs of nursing I hold to be this: that you have created a demand for your services even before you knew them all, and then met the demand in a fashion to create still more calls upon you. "... never forget," wrote Wordsworth to Lady Beaumont, "that every great and original writer in proportion as he is great or original must himself create the taste by which he is relished..."* You have ignored chilling skepticism, and outlasted the shocked pruderies of your superiors, and proffered unimagined help. But it is not a task that is completed. More remains to be done. It is a sad fact that physicians so often limit themselves to their own imagination of what nurses can do and try to decide how nurses should do even that, but so rarely ask nurses to set forth their capacities or leave them to correct old ways or contrive new ways of being helpful. But the remarkable fact remains that as much as any profession, and more than some, the nursing profession has known how to extend the boundaries of its usefulness by the relentless pressure of imaginative minds.

Nor is it a question of merely being useful. To a French professor I posed the question once, "What has the Rockefeller Foundation done in France that may be of real significance?" He replied in this wise:

I hope you will excuse me if I do not mention medical research, but truly the greatest benefit in my opinion comes from your help in the education of nurses. You see the usual

French physician after his training was completed under other physicians, became a person whose professional work (unless he had pupils or assistants) could easily be done without observers and without control of any kind. No untrained nurse was capable of more than rudimentary services, but a *trained* nurse—ah, then the situation changed, and with a well-trained nurse the doctor now obtains a welcome assistant to his best efforts and an intelligent witness of his weakness. Quite true that is not always agreeable, but the general advantage to the profession and to the sick is undeniable.

That is a function of nurses so constant among us that it has been fused like an amalgam and lost to conscious recognition.

DOCTOR-NURSE RELATIONSHIPS

Time does not permit me to discuss the complicated relationships between doctor and nurse. It is too big a field and too changing a field for casual reference or hurried summation. Nonetheless one point I'd like to make in the form of advice given to us as senior medical students in 1916 by George Gordon, the minister of the Old South Church in Boston. We asked him to talk to us about doctors as seen by a minister of the Gospel. This was about what he said:

I have often observed how remarkably a man's professional associations eventually affect his manner of thought and feeling. Now I have served on many civic committees where I have watched the behavior of professional men, and it would be my considered judgment that if you are ever on a civic committee of one kind or another you'd do well to respect the professional experience of the members of the committee. You'd do well to divide the work into different parts according to the professions represented.

For the work of examining the status quo, no matter how bad it is, and making a report on it you'd do well to use the doctors on the committee. They're honest men trained to observe and in touch with all parts of the community, accustomed to knowing the worst and doing the best they can. But doctors have one great defect. They've been so surrounded by obsequious nurses, frightened patients, and timid families that they're not accustomed to being criticized or having their recommenda-

*Knight, William, editor. *Memorials of Coleorton*. David Douglas, Edinburgh, 1937, vol. 2, p. 17. "Letter of Wordsworth to Lady Beaumont, May 21, 1807."

tions challenged by any living man or woman. So take the doctors' report arbitrarily out of their hands and turn the duties of discussing what's to be done over to a committee of lawyers.

Now the lawyers have one great quality; they have the hides of rhinoceroses. They are quite capable of criticizing each other's suggestions mercilessly all the afternoon and still dining amicably together in the evening—which is more than the doctors can do. But the defect of the lawyers is that they would be willing to go on that way forever. So, when the fifth plan suggested (and amended twice) begins to look suspiciously like the first suggestion that was made, it's time to take it out of the hands of the lawyers and hand it over to the business men on the committee. Now the business man is congenitally incapable of examining anything, but he has one grand quality. When given a clear idea of what he is to do he will seize upon it like a dog with a bone and carry it through.

"Frightened patients"! Do we often stop to realize what the effect is upon both nurse and doctor of having so steadily to deal with weak, dependent, frightened patients and anxious relatives? Quite bluntly I think it makes us arbitrary, supersensitive to criticism from forceful, healthy adults, and dictatorial and impatient of challenge or direction. Lord Acton wrote relentlessly two words that explain much, "*Power corrupts.*" And the fact remains that the sick must be managed and in fear and distress will seek until they find a manager. So, because of the finite span of human life, and the inexperience of every oncoming generation, and because of a human weakness for the neatness and dispatch of arbitrary decision, there is no lasting solution to the clash of persons accustomed to lead the sick, unless they prepare themselves intelligently to resist the weaknesses of all dictators—fear of contradiction, exploitation of emergencies, and personal vanity.

VALUE OF EXPERIENCED SKILL

And now with one more extraordinary characteristic of nursing as a calling I draw to a close. There are two ways of learning anything—one through sym-

bols, such as the written or spoken word, and the other through experience. Through reading and listening we may acquire a tremendous range of information, it is true, but the learning derived from experience and practice leads to skill. Book learning leads to erudition but only the learning coming from experience can impart skill. That is a very curious and very significant fact. But even more remarkable, it is only from skill that we derive joy and courage.

The more I see of erudition the less I estimate its value in comparison with experienced skill. Those who belabor the nursing schools to give more theory and more book learning to nurses see doubtless still some imbalances needing to be redressed, since to intelligent, well educated girls the denial of intellectual understanding of what they are to see and do is a stupid amputation of their future usefulness.

But book learning and theory unadjusted to generous amounts of experience in observation and in work are likely to cheat the nurse of the chance to acquire competence and common-sense. Or it may postpone the recognition that she really has no capacity to make sound judgments. There is nothing like a long period of book learning for saving essentially incompetent young people from an early showdown. The experienced nurse may be a real protection against a similar defect in the doctors' training—lack of general experience, the blindness of the expert, the incapacity to weigh all kinds of information and pick, out of everything, the simple and significant. This is no defense for drill and drudgery but a plea for attentive experience in the training of an alert and dependable human being. Stephen Ward remarks, "Such conceptions as happiness and unhappiness are really foreign to life. There exists neither the one nor the other. There are degrees of interest only." Joy

and courage! Has there been any time in the past twenty years when the world had more need of joy and courage?

PROFOUND CHANGE NOW INEVITABLE

The war in Europe is no mere military struggle. It is the forerunner of profound and sweeping change, cruel and disastrous, no matter who "wins." Biologically war kills the fittest, the conscientious, the loyal, more commonly than their opposites and removes such heritage and example from the human stock. As Hans Wendt says, "Only compulsion makes men evil and destroys their sense of the value of human life." Further, war reduces the birth rate and limits the growth and future vigor of war-nourished children. As to economic and civil liberties it is unnecessary to predict their disappearance for they have gone: you may talk about when they may reappear if it please you, for liberty is the price of modern war, not its dividend.

By so much as modern inventions have compacted this troubled world we are all together. During these next years we shall have ample opportunities

to face evil with equanimity, to form and to live by an independent estimate of nursing. For, as Paul Bourget says, "You must live as you think. If not, sooner or later you will end by thinking as you have lived." It is for this reason that we should seek more honestly and more earnestly than ever before to find what really matters to us, what beliefs and convictions we have and hold.

And now I come to the end, dubious of success but sure of the intent and purpose of this talk—to encourage you to have and to hold an independent estimate of nursing in our times. For the honor of speaking to you I am grateful. For any justification for speaking I am still at a loss, but to justify immediate silence let us recall the mellow question of Lao-Tze, still fresh after twenty-four centuries, "May not a man take muddy water and make it clear by keeping still?"

Presented before the Joint Session of the three national nursing organizations, Biennial Convention, Philadelphia, Pennsylvania, May 16, 1940. Published in *The American Journal of Nursing*, July 1940.

NURSES OFFER SERVICE

In view of conditions abroad, the National Organization for Public Health Nursing at its Biennial Convention in Philadelphia on May 17 sent a message to Dr. Thomas Parran, Jr., Surgeon General of the United States Public Health Service, pledging the support of any public health program planned for the protection of our citizens.

The following message was sent to the President of the United States by the A.N.A. and the N.L.N.E.:

WHEREAS this is a time of unusual anxiety and concern to this nation and of great responsibility for the President of the United States, be it RESOLVED that we, the delegates of the American Nurses' Association, and members of the National League of Nursing Education, now assembled in convention in Philadelphia, wish to offer the support and strength of our organizations in any nursing activity in which we can be of service to the country.

A Board Member Goes to the Biennial

By PRISCILLA K. THAXTER

IN PHILADELPHIA on May 13 more than 7500 people, mostly nurses, were gathered for the 1940 Biennial Convention. All were committed to promote health throughout our land, and all were very solemn and earnest about their commitment.

Of course, the war permeated many of the discussions, as one would expect it to. Automobiles with radios were popular meeting places at the times of news broadcasts, and the latest editions of the newspapers were in great demand. As I sat with that group of 7500, I could not help but compare their role with that which nurses were filling abroad. Two years ago, had they been planning similar meetings in Oslo, Antwerp, Paris, or London? If so, how suddenly had their plans been changed!

Dr. Hubley R. Owen, director of the Philadelphia Department of Public Health, welcomed us, and it proved to be a welcome indeed. The hospitality extended to this board member by residents of the convention city and nearby cities was greatly appreciated. So much so, that I regretted my inability to do anything to help when the lovely Rittenhouse Flower Mart was rained out.

SPIRIT OF CONVENTION CONTAGIOUS

Mr. Kenneth L. M. Pray in the introduction to his talk on "The Community's Role in Health Promotion" quoted a celebrated cynic as saying that if he had been the creator he would have made *health* catching instead of *disease*. He continued by saying, "Positive health is contagious." I certainly felt that the spirit of the convention was contagious and I returned to Portland determined to do everything in my power to promote health education. I felt that one

of the outstanding messages in the convention was the great and crying need for a better informed public, whether it be school child or adult. To educate them *is* the responsibility of every health worker.

Mary Gardner and the "hazy glow" she created at the Membership Rally luncheon when she gave advice to the speakers of our day will stand out as one of the great occasions of the week. It is impossible for me to convey the spirit of her talk, but I am sorry for those who were not able to attend the convention and hear her. In fact, there were a great many stimulating discussions and talks. The panel on "How Can School and Community Join Forces to Serve the School Child?" conducted by Geraldine Hiller of New Rochelle was a model well worth emulating. For with clarity and purposefulness, with charm and conviction, the participants so enthralled their listeners that the room was packed and many stood through the entire session. Mr. Ignatius D. Taubeneck, director of Bronxville Community Forum and lecturer on Community Problems at New York University, summarized their findings.

The speech which Dr. C.-E. A. Winslow delivered at "his dinner" on "Housing and Health" will be quoted throughout the country. Also quoted will be Mrs. Curtis Bok's address on "Civic Education" in the symposium on "The Preparation of the Nurse for Leadership in a Democracy." A striking example of the need for coöperation was Mrs. Bok's illustration of the dependency of the surgeon on the "scrub-nurse." The qualities of thoroughness and worthiness are necessary in every step of great endeavor, and the work of the man at the

top is in a very large measure based on the activity of the one at the bottom. "We cannot all be leaders, and no leader can go far without followers. We must settle our own problems and be familiar with the techniques in the democratic process," said Mrs. Bok. She advised that we conduct our proceedings in an orderly manner, familiarizing ourselves with parliamentary law through "Roberts' Rules of Order." Her warning note to all and particularly to those of us who are board members, was that we plan a wiser use of our time and not lend our names to activities unless we actually do work for them. She said the time had passed when a list of the same familiar names for all endeavors in a community means anything to the public.

"No government is better than its leaders," said Mrs. Bok, "and as we have professional standards for nurses and teachers, may we have professional standards for our politicians." She suggested that we should be vocal and keep some penny postcards on our desk to send to the editors of newspapers when things appear that we question.

She stressed the need of seeing the community as a whole.

It has been said that we do not make friends after we are thirty years old, but the Biennial proved this to be a false supposition. Acquaintanceships rapidly developed into friendships, along with the discussion of mutual problems. Nursing agencies of one, six, or three hundred nurses became Mrs. Kane's, Mrs. Wallace's and Mrs. Lilenthal's* problems. Even the National Organiza-

tion for Public Health Nursing ceased to be a mouthful and became human, after personal contacts with those who in the past had so patiently sent our agencies volumes of material, never failing to answer our most baffling questions to solve our most complex problems. My feeling is that we, as board members, should join our National Organization, and in fact, should follow Mrs. James K. Watkins' splendid example in Detroit and have many 100 percent board memberships by the next Biennial.

My district nursing board was amused when I told them that I had returned from Philadelphia with ideas for every organization in town, and I think that best illustrates the scope of the convention and its application to the everyday problems which confront us. More and more we realize that we must cooperate with existing agencies and together educate the public in regard to the needs of the community. Surely the health needs are a challenge to all right-thinking people, and recognizing their worth, we must survey for needs, become informed, disseminate knowledge, and demand improvement.

I had one proof of the smallness of our world, which was at the same time one of my happiest convention experiences. Katherine L. Quinn, who has been with the Health Department of Portland, Maine, for 23 years, introduced me to Harriet Hohenfeld who is at present with the New York City Department of Health. Miss Hohenfeld told me that in 1908 she had worked with our Portland District Nursing Association when my mother-in-law, Mrs. Sidney Warren Thaxter, was president of the board. They had built what we today are endeavoring to carry on, and it is my earnest prayer that we may keep faith with those who came before, and build, as well, for those who follow.

*Mrs. Edward Winslow Kane, president, District Nursing Association, Ossining, New York; Mrs. Eva K. Wallace, board member, The Visiting Nurse Association of Omaha, Nebraska; Mrs. Joseph L. Lilenthal, member, Nursing Committee, Henry Street Visiting Nurse Service, New York City.

A Colorado Nurse Goes to the Biennial

By RUTH E. PHILLIPS, R.N.

EVERY STATE in the Union and several foreign countries were represented by nurses in Philadelphia, May 12 to 18. What was the magnet that drew over 7500 members of the world's largest organization of professional women to this center? It was the National Biennial Nursing Convention. The convention theme was "Nursing in a Democracy."

As we drove from Denver to Philadelphia, we revelled in the great expanse of country that spring was decorating so lavishly. The tree-covered Appalachians, studded with flowering dogwood, offer sharp contrast to the Rockies. As our radios brought the news of the invasion of Belgium, The Netherlands, and France, we were shocked at the plight of democracies abroad. Even in Philadelphia, the shrine of American history and liberty where we were welcomed and entertained, we could not escape the impact of this threat to democracy—War.

Why should nurses deliberate on "Nursing in a Democracy?" In the United States, we have lived and talked "democracy" for a century and a half. We have never felt that it has gained its full stature nor that it has operated satisfactorily in all fields of endeavor. We have not always agreed as to the exact meaning of democracy but we have always agreed on certain fundamental principles. These include freedom of speech, press, and assembly.

Professional nursing had its origin in the latter half of this period. It has, we feel, gained stature but not full stature. Fostering its growth are those democratic principles of assembly, speech, and press that were so much in evidence on the agenda of the Biennial.

The concept of democracy also implies that we will act when we understand our problems. What better means to determine our action than a meeting of minds around the conference table? Symposia, panels, and round tables gave variety and wide choice.

"The Preparation of the Nurse for Leadership in a Democracy" was a symposium offering much to us all. A few of the highlights follow:

Democracy can be lost by guns and machines but democracy cannot be won thus.

Leaders with vision are needed in a democracy. We need forceful influence, not forceful control.

Those who do the work should be represented on the governing boards in schools, hospitals, and other agencies.

No other group can settle nursing problems though many can help.

A moral issue should be discussed when it arises, and by all concerned. (How helpful this proves in staff problems!)

We need education for usefulness rather than for leadership alone.

The family is the threshold of democracy. Democracy is made safe only as the home is made safe. Skilled medical and nursing care safeguard the expectant mother, the injured worker, the sick child, thus preserving this threshold. The fact that experts in maternity, in nutrition, in hospital administration, in volunteer and staff service all contribute to such care was shown in this conference.

Does discussion stimulate thinking? We can be reasonably certain that nurses, their boards, and the public will sense the problems now presented by subsidiary workers only when they understand how health, safety, and professional standards are affected by these workers. Nothing throws light on prob-

lems more effectively than discussion so handled as to bring about progressive thinking, and the determination to use all available facts in understanding the issues. The report of the Joint Committee to Outline Principles and Policies for the Control of Subsidiary Workers in the Care of the Sick showed great progress and an enormous amount of work since the 1938 Biennial. It reveals that the nursing profession has contributed study, instruction, guidance, supervision, and leadership. One quick-thinking discussant from the Pacific Coast suggested that these contributions are worthy of a better title than "control" and that this word is not appropriate in a democracy. A further suggestion is that the subsidiary workers themselves, largely unorganized at present, be drawn into the planning that concerns them, because this too is a principle of democracy.

What trends did we note in the vast panorama of meetings? The popularity of special study on public health nursing subjects for two days before the convention increases. The authoritative approach, too common among us in the past, has given way to the persuasive approach in our relationships with patients, staff, volunteers, and the community. Like a thread running through most sessions was an increasing awareness of the

value and importance of lay participation in hospital, home, industry, and community work.

Anyone who attended the N.O.P.H.N. Membership Rally luncheon will remember it as the most fun of the whole Biennial. Our beloved Mary Gardner carried us through the most delightful half hour of our stay in Philadelphia with her gentle satire on how to present a speech. She admonished, "Have nothing to do with facts. They are vulnerable to challenge and they are too hard to get." She told us to aspire for a "rosy glow and a golden haze." The quartet that parodied our membership campaign added to the general good cheer. Because humor has value, especially in a period of strain such as the present, this session was a timely astirgent.

Our national organizations and our hostess state had planned with great care for our pleasure, profit, and comfort. We felt welcome in this city, rich in history and accomplishment. Two other visitors and the writer were invited to ride along the beautiful parkway of the Schuylkill River by a volunteer, who needed only the evidence of our badges to inspire her hospitality . . . We were entertained and instructed. Now, we are ready to carry nursing in a democracy to new high goals.

CONVENTION PAPERS SCHEDULED FOR AUGUST

The Health Council—Ira V. Hiscock, Sc.D.

Telling Our Story Through Radio—Anne M. Lawton.

Planning for a Rural Delivery Service—Helen B. Buker, R.N.

The State of Our Finances—W. Lawrence McLane.

The School Panel at the Biennial.

Several other papers from general sessions and round tables will appear in subsequent issues.

Our Task in a Changing World

By GRACE ROSS, R.N.

THESE are healthy times for public health nursing, because at no previous stage of our history have we been more critical of ourselves and our work or more appreciative of the constructive criticism of those capable of helping us.

All about us we hear the cracking of the confining walls which have impeded growth—in the social order, in the economic world, and in our very own nursing world. Patterns of schooling in the past have prepared us to perform our life work on an individual, person-to-person basis. There has been little obligation toward an over-all plan of combined usefulness and purpose in community life, and we are aware of the stresses which now confront us as a changing world proves our preparation to be inadequate.

To live implies planned growth. In the midst of shattered patterns, some of them our own, we have a choice to make between painful disquieting growth or secure, comfortable decay. It is to the credit and glory of public health nursing that it chooses to live strenuously and reaches up and out into the changing order to find and be responsible for its own particular contribution to group life.

Our organization is able to present some tangible results in support of our statement. First is the reaction of our Board of Directors to the National Health Conference held in July 1938, to the report on the National Health

Program, and to the work of the Interdepartmental Committee to Coördinate Health and Welfare Activities, to which our organization sent representatives. We went on record as advocating the coördination of official and voluntary agencies in health planning which aims to conserve health and reduce illness. We advocated the services of qualified advisers from the allied fields including our own; the adoption of a plan of home nursing care of the sick; industrial nursing, especially in small plants; expansion of the maternal and child health programs to include medical and nursing care at the time of delivery; care of the premature baby and of the handicapped child. And we approved the expansion of hospital, clinic, and other institutional facilities and medical and nursing care to the medically needy.

We also stressed the value of lay groups and citizens on advisory committees; the need for guarding standards for personnel; the need for supervision and for more readily available facilities for adequate preparation of personnel. We have asked that where states establish their own health insurance systems, nursing care approved by the professional organizations shall be included among the benefits.

A second item to prove our constantly growing usefulness is the development of standards in our field which are adopted and put to work by others in the national field. Examples are the "Minimum Qualifications for Those Appointed to Positions in Public Health Nursing"* accepted by the United States Public Health Service and by the United States Children's Bureau and now becoming

Address of the president of the National Organization for Public Health Nursing, presented before the Biennial Convention, Philadelphia, Pennsylvania, May 14, 1940, published in the N.O.P.H.N. Biennial Report, 1938-1940, New York, N. Y.

*PUBLIC HEALTH NURSING, March 1936.

effective through the merit systems in all states where federal money is used.

SERVICE IN SPECIAL FIELDS

Exhibit three is our effort to improve public health nursing in special fields. You are familiar with the work which Jessie L. Stevenson—who was generously spared to us by the Visiting Nurse Association of Chicago—is doing, developing an orthopedic nursing program, conducting institutes, advising in regard to the content of courses, and preparing a manual for orthopedic nurses in co-operation with the National League of Nursing Education. We know how gratefully this contribution, made possible by the National Foundation for Infantile Paralysis, will be received throughout the country. The attention of the staff is being directed more and more toward the development of better maternity service in rural areas. And we are still hoping that a project comparable to Miss Stevenson's can be promoted for industrial nurses. We remember that of all the men in industry, 62 percent work in plants employing less than 500 each and these plants are financially unable to carry a health service of their own.* We also remember that there are 62 percent more lost-time injuries in these plants than in large ones.** How grateful we should be if we could afford to offer practical, up-to-the-minute assistance to this field.

We are encouraged by the steady progress which is being made in better preparation of public health nurses. It is evidenced in more programs of study in public health nursing in colleges and universities, 26 being the number of such programs approved by the N.O.P.H.N. at this time. Our field has

been in large measure a justification for adopting the much needed higher standards of selection of students in schools of nursing. Work with the Curriculum Committee of the National League of Nursing Education has been a means of insuring better preparation of students for future public health nursing. The institutes in special fields for which the N.O.P.H.N. is being constantly bombarded are a stimulating reminder that the nurses in the field are anxious to meet the increasing demands of their own work. How we wish we could afford to meet these requests in more generous measure!

We rejoice that our field is an expanding one, that it assumes the inclusion of more bedside care for the sick in rural areas, and that better work is being brought about through supervision furnished by federal, state, and local agencies.

CHANGES IN OUR PHILOSOPHY

There are other changes, also, in our philosophy, which hail a sounder day. We are no longer impressed by large totals of visits made, of persons seen, of miles covered. We are interested in what a nursing visit costs, and what we get for its cost; in what detrimental patterns of family life we successfully change; in what impaired physical conditions we definitely improve or correct; in the amount of instruction which holds over from one situation to another; and in many other results of visits made. Quality of service has replaced quantity of service as a goal. Most of what we do can be measured and those who underwrite our services have a right to know that they get what they pay for.

Another change for the good is that we are no longer impressed by an academic degree *per se*, having learned that personality is the pearl of great and first price to which other advantages, including degrees, should be added. We have learned that limited, specialized

*Houlton, Ruth, "Nursing Service for the Small Plant." PUBLIC HEALTH NURSING, September 1939, p. 515.

**Newquist, M. N. Medical Service in Industry and Workmen's Compensation Laws. American College of Surgeons, Chicago, 1938, p. 29.

superservices are not the best answer to the total health needs of the community. This leads us to the finest objective toward which nursing can direct itself—to community nursing service. The true democratic ideal has not been reached in nursing any more than it has been in any other phase of our community life. That we have an obligation to define and to provide adequate nursing for all the community is not admitted by all nurses as yet—only by those who believe that democratic living can and should be a reality and that nursing has its role to play in it. That all nursing needs shall be met and that all who need nursing shall be adequately served are without doubt the goals toward which these changing times are directing us—whether we like it or not.

The N.O.P.H.N. believes that we should help to shape this pattern and not wait until the community fits us into some pattern of its own choice. When we see the need for coördinating health services in each community, the need for bureaus and councils to work out these problems; the need to get together the people uncared for who need care, and the nurses needing work who have none to do; the allocation of the "right" patient to the subsidiary worker who is incapable of properly serving the "wrong" patient; and the wonderful opportunities for nurses and for patients potentially possible in the insurance and prepayment plans when they become enlarged to meet all the needs of the sick—we are compelled to action.

Our organization is much engrossed in all these problems and believes that it can play a helpful role in their solution. "Our organization" means every one of us, and what a challenge to us! Think of the vast power for good we could muster if each one of us could sell our N.O.P.H.N. to at least one lay person who would join with us and help to bring about all these worth-while ac-

tivities. We have done a fine job so far, but think what could happen if every public health nurse in our land would get behind our program, build up a large, strong lay section, and through this enlarged membership find the funds to carry on these timely projects. We could then assist in those fields of public health nursing which have not yet received their just share of help. We could study sound methods and guarantee to ourselves without worries that fine brand of leadership to which our staff has accustomed us.

OUR RESPONSIBILITY

Ours is a grand profession. The challenges in our special field are legion. We believe that every nurse on the job is potentially a leader in our bigger and better development, and that makes it the responsibility of every one of us to help find the means of underwriting more generously our national program so that it can fulfill all of its obligations. I firmly believe that all of us, pulling together, can and will reach our goal.

I wish to thank the Board of Directors for their fine attendance at board meetings and for their active, thoughtful, and challenging participation. I thank our fine staff for the splendid way in which they have carried on, and especially our general director, Dorothy Deming, for her alert attention to all that promotes our program and for her forward-looking and forward-moving activities. These you will have the pleasure of hearing about in her own report to you.* And last, I thank you, our membership, for the privilege of serving you these last two years. It has been a broadening and enriching experience to me—much enjoyed and much appreciated.

*The report of the general director is published in the Biennial Report, 1938-1940, National Organization for Public Health Nursing, 50 West 50 Street, New York, N. Y.

The Community's Role in Health Promotion

By KENNETH L. M. PRAY

The professional worker has a responsibility for helping the community realize the basic interrelationship between economic, social, and health problems

IT IS one of the achievements of our time in public health administration that we have been able to recognize and deal with the problem of ill health not as an isolated phenomenon, controllable only by a special set of technical devices, but rather as one side of an unbroken triangle of problems and hazards confronting every individual and family in our society. The social and economic legs of that triangle, which have been brought into bold relief by the experience of the last ten years in this country, are inseparably linked with physical and mental health aspects of living, and a sound attack upon any one depends upon a concerted movement toward sound goals of living in all three. I advance the thesis, therefore, that the uniting of community resources for health is an indispensable and inseparable factor in a planned community program for social and economic well-being.

There is little need to justify these somewhat dogmatic statements with recitals of detailed facts and figures. They are common knowledge, imbedded in the experience of all who minister to the needs of human beings in trouble. One illustration will suffice—the problem of housing. Unsafe, unsanitary, overcrowded living quarters obviously constitute a health hazard of the first rank. Health education and health treatment will of course somewhat minimize the consequences of bad housing, and the organization and coördination of the necessary health services to reach into

these dark and dismal places are an essential element of civilized community life.

From another angle of vision it is clear, however, that not health alone is at stake here. Nor is health service sufficient unto itself. The lack of privacy, the depressing, deteriorating effect of these undesirable surroundings, the constant tedium and irritation of continual crowded contact with others, must often account for family strains and social maladjustments. Again, intelligent and devoted social services can by the use of their own specialized methods alleviate some of the dangers of this social environment and can help some families and individuals to surmount many of these handicaps. Provision of such service is another essential element of a civilized community's scheme of life.

ECONOMIC ASPECT FUNDAMENTAL

But it is obvious not only that the social and health phases of this human problem react upon and intensify each other, but that both are bound up with a third—the economic phase, and that neither health nor social adjustment can be assured by even the most expert professional service of social workers or of health workers. Hampering and often frustrating both is the basic economic inadequacy of a large section of the population, and this, too, demands further community treatment if health or social fitness is to be attained.

Good housing, for example, is some-

thing vastly more than disease prevention, or crime prevention, or the prevention of family and individual breakdown and demoralization. It is one of the bases of the good life, from which, alone, real health—physical, mental, social, and economic—can grow and flourish in any community.

SOCIAL ADVANCE ON THREE FRONTS

This is but one simple illustration of the basic principle upon which rests the progressive unification of community effort for health. It imposes upon professional workers a common and imperative responsibility for helping to awaken the community to a real appreciation of the basic interrelationship of economic, social, and health problems, and for summoning the community to a concerted advance on all three fronts, in accordance with a realistic and comprehensive plan. This preventive and constructive purpose is an inherent part of professional responsibility.

I am not calling you here to a social and economic crusade, nor am I enlisting recruits for a social revolution. I am, rather, charging you, as you cherish the fulfillment of your own professional aims and the maintenance of your own professional integrity, to lend the weight of your expert testimony to the advancement of those fundamental public policies that are the indispensable foundations of your own professional achievement. Can there be any doubt, for instance, that a family well housed, well fed, creatively employed, under conditions that afford the satisfactions of just compensation, a sense of personal dignity, and an opportunity for constructive participation in community life, can and will make more effective use of professional services for the fulfillment of their individual need? Can we be satisfied, as professional people, with the perpetuation of conditions that inevitably limit the values of our own professional performance?

PROBLEMS NOT INSUPERABLE

The vastness of the problem which such concerted planning and action involves, taking into account the local, state, and national ramifications of all these problems, may seem overwhelming at first sight. But when it is broken down into specific items and projects, it is not completely unmanageable, provided only that the community has the leadership of informed and responsible professional groups, with no selfish interest obscuring a realistic approach to practical facts and a determined effort to serve human beings.

Fortunately, one of the gratifying outcomes of the period of conflict and confusion through which we have been passing is the steady accumulation of incontrovertible, objective fact upon which to base a rational judgment of the extent and kind of pressing needs. No period of depression and social disorganization in the past has been analyzed and measured with anything like the same intensiveness and accuracy that has characterized the social research of the last decade. With such tools as these at our disposal, we cannot evade the responsibility for making the highest possible use of them.

ECONOMIC LOSS FROM ILLNESS

First of all, we know the staggering amount of disabling illness itself and the inadequacy and unevenness of systematic provision for meeting it. On the basis of the returns of the National Health Survey of 1935-1936, confirmed by the studies of the Interdepartmental Committee and by innumerable supplementations of both in local and regional studies by competent and disinterested authorities, we know that in any year there are tens of millions of disabling illnesses in the United States; that on a typical winter day, there are millions of persons in American cities unable to go about their usual occupations because

of illness or injury.¹ We know that at least a billion working days are lost each year on this account, representing an economic loss of considerably more than a billion dollars each year in addition to the cost of caring for these disabilities and their consequences.²

ILLNESS MORE AS INCOME FALLS

Most of all, we know that these losses pile up more heavily in precisely those families that are least able to bear them. Families having incomes of \$1000 a year or less, on the very margin of subsistence—and they constitute more than one third of all families in the country³—experience serious disabling illnesses far more often than families having the relatively comfortable income of \$3000 or more; while families on relief, whose incomes are far less than \$1000 a year in the overwhelming majority of cases, have an illness rate fifty percent greater than those in the upper income group.³

Even more striking is the fact that the increase in *frequency* of disabling illness is accompanied by even greater increase in the length and severity of illness, as income declines. Chronic illness, for example, is almost twice as great among families on the relief rolls as among families with incomes of \$3000 or more.⁴ These disabling illnesses also last longer in the low-income families, so that the actual length of disability in the relief group is three times, and in families just above the relief level, two times, as great as in families in the comfortable income brackets.⁵

In our view of the problem as it relates to my thesis, it is exceedingly significant that as income rises to the point

where a reasonably adequate standard of living is usually attainable—that is, above \$2000 a year—the extent of disabling illness steadily declines, so that the difference between those in the middle-income brackets and those in the higher groups practically disappears.⁶ In other words, if we could raise minimum income to even a decent level, we could practically assure a certain reduction in disabling illness.

HEALTH SERVICE INADEQUATE

Perhaps even more significant is the striking fact that the health service rendered to these low-income groups is woefully out of proportion to needs. During a recent period in which, under federal stimulation and assistance, medical service for the recipients of relief was relatively more extensive than ever before in history, the percentage of disabling illnesses in which no physicians' care was given was two to three times as great in relief families as in families of higher incomes, and the percentage of unattended illnesses steadily increased as income declined.⁷

In the area of nursing service, the discrepancy was even more conspicuous. Eleven times as many cases, in proportion to numbers, in the \$3000 income class had the benefit of bedside nursing care as in the relief and marginal groups of families.⁸ When one recalls that illnesses among these low-income families last longer and are more severe, on the average, the unfavorable discrimination is even more appalling.

³ The Need for a National Health Program, *op. cit.*, p. 23.

⁴ *Ibid.*

⁵ *Ibid.*

⁶ *Ibid.*

⁷ *Ibid.*, p. 25.

⁸ *Ibid.*, p. 26.

⁹ Division of Public Health Methods, National Institute of Health, United States Public Health Service. The National Health Survey: 1935-1936. Preliminary Reports, Population Series, Bulletin No. C. Washington, D. C., 1938, p. i.

¹ Interdepartmental Committee to Coordinate Health and Welfare Activities. The Need for a National Health Program. Report of the Technical Committee on Medical Care, Washington, D. C., 1938, p. 1.

² Interdepartmental Committee to Coordinate Health and Welfare Activities. The Nation's Health. Washington, D. C., 1939, p. 51.

Whatever else these figures prove, they surely demonstrate that the uniting of community resources for family health necessitates the restoration and maintenance of standards of general living upon which the fundamental conditions of health can be sustained. They prove that a general social policy which does not protect a reasonable level of security and adequacy in wages, working conditions, and living conditions is helping to create or to perpetuate health problems faster than they can possibly be conquered. Needless to say, they prove also that a public relief policy which does not provide a standard of living at a level of "decency and health," as many present laws require in theory though unfortunately not in practice, is actually condemning thousands of people to a state of more or less continuous ill health.

Viewed in the mass, the complicated problem of raising the standard of living seems almost insuperable. Tackled one specific issue at a time, as opportunity presents itself—through relief policy and administration, through economic regulation and stimulation, through housing promotion—definite progress can and will be made. We as social and health workers, whatever the area of our technical service, have a stake in that process of community action and hence an important share in the responsibility for its guidance and support.

Certain courses of action are immediately open to us. We can recognize for ourselves and help the community to realize the validity of the insurance principle in providing a reserve against the critical moment when illness strikes down the bread-winner and threatens to reduce, if not utterly to wipe out, the already minimum standard of living to which the family is adjusted. We can help to assure by means such as these that families shall at least not fall still further below a tolerable level of physical existence.

I am reminded of the moving little story told by Helen Hall, of Henry Street Settlement, at the National Health Conference in 1938, about a little girl who ran up one day to say to her, "Oh, Miss Hall, but we are God-lucky in our house. Mother got sick on daddy's pay day." It is worth while remembering that if daddy had "got sick," in millions of homes in this country, there would have been no more pay days and the family would not have been so "God-lucky" as that one seemed to the little girl.

It is conceivable of course that mother's illness may be a drain on the family resources, even when it falls on daddy's pay day, and even if daddy goes on working and has other pay days; and that its costs may have to be taken out of the food and the rent and the clothes that the little daughter might require for her own health or for her own sense of social fitness and personal adequacy.

Is that an economic problem, or a medical problem, or does it go by that high-sounding title of "medical economics"? Whatever it is, it is our problem, as it is the community's problem, and it cannot be solved without the energetic and determined coöperation of all those who are genuinely concerned with the promotion of health, with social adjustment, and with economic reform.

A LEAK IN THE FAMILY BARREL

From the standpoint of public health the important thing to remember is this: That so long as the family barrel has a leaky bottom, in its inadequate and intermittent opportunities for nutritious food, adequate shelter, and the like, the resources we pour in at the top in an effort to raise the health level are oozing out rapidly below. It is our concern as professional people, not merely to man the buckets that fill the barrel but also to help plug the holes at the base.

It is true, of course, that we cannot await the often painfully slow process

of fundamental social and economic repair and rehabilitation. Human suffering lays its own heavy claims upon us. People need us now, and we must answer with all the professional skill and devotion we can muster, even though we know that for lack of basic social and economic individual security much remedial care is wasted and more is demanded than otherwise would be required. In that dilemma we have no choice but to provide, and to help the community provide, the added service. Even this is not an isolated professional concern of ours. It, too, is a matter of public policy, of community collaboration, to which we must address our continuous earnest efforts.

THE GOAL IS THE IMPORTANT THING

And around this program, we must not be drawn off into futile argument around immaterial issues. Is this provision of necessary health service to be provided on the traditional basis of the acceptance of professional obligation by individual practitioners to meet every legitimate call from those in need? Is it to be on the basis of philanthropic provision, in advance, of the means to guarantee a reasonable compensation of practitioners, as well as a reasonable distribution of service? Is it to be by the use of the taxing power to equalize and universalize the opportunity for service, and to standardize and reinforce individual and group responsibility?

We may not have the final voice in the answering of those complicated questions, and we may not agree as to the right answer. Indeed, probably no one answer will always be right. The solution will doubtless lie not in any one of these alternatives, but as in the past, in a shifting combination and continually advancing integration of them all. The decisive fact is that we cannot afford to allow ourselves or the community to be mired in disputes as to method. The vital thing is to move forward *somehow*

to the fulfillment of needs that are clear beyond argument and that involve the deepest interests of tens of millions of human beings, whom we have the most imperative obligation to serve.

FOUR PARAMOUNT CONSIDERATIONS

Four dominant considerations face us as professional people in our appraisal of and participation in such a program, whatever the details of policy and administration may ultimately prove to be.

First, our own recognition, and our profound obligation to help the community realize that health is a primary concern of the whole community, and that this community concern for the health of the individual does not begin when the citizen reaches the bottom of his own resources, nor does it end when he reaches a barely tolerable level of self-sustaining existence. It is, if anything, more important that adequate health service be made available to those who only feel the threat of economic breakdown than merely to those who have felt its full impact.

Second, our own honest conviction, shared bravely with the community at every suitable opportunity, that the standard of living which the community imposes in the form of relief for those who are dependent, and which it tolerates in the form of wages for the independent worker, determines almost directly the extent and the cost of the health service which these citizens require and which the community must in some form provide.

Third, our own unwavering faith and our own professional obligation in behalf of our clients and patients, to help the community recognize that the most economical and effective program will be one that unites continual efforts to raise the standard of living with a determined purpose to make accessible to all who are unable to meet their own needs the full benefits of the consolidated services of physician, nurse, dentist, hospital, clinic, and social worker.

Fourth, our profound responsibility to make sure that health services shall be administered under the responsible direction of those who are professionally competent to judge the need and to apply the aid, without the ignorant or vicious interference of any selfish interest, political or otherwise; and to see that they are administered with direct accountability to a suitably equipped public authority for the faithful performance and suitable distribution of services made possible, in whole or part, by public funds.

This does not mean necessarily nor even probably, the institution of a general program of so-called state medicine in any real sense, though it will inevitably mean the extension of employment and compensation of competent professional persons by public authorities as well as the provision of additional care by private practitioners and philanthropic agencies.

It will mean, also, the development of more intensive supervision and regulation of these services so vital to the welfare of human beings, by public authorities who are dominated by professional knowledge and spirit and determined to protect the total public interest against

incompetence, selfishness, and every other uncontrolled or illegitimate private interest.

In the last analysis it will mean, of course, the true socialization of health service, not in any narrow or prejudicial sense, but in the larger and truer meaning that health for its own sake and as an inseparable element of social fitness and progress will be a valid social goal, and that the universal provision and proper distribution of health service will be a vital and regular responsibility of the whole community.

Presented before the N.O.P.H.N. General Session, Biennial Convention, Philadelphia, Pennsylvania, May 14, 1940.

News from the S.O.P.H.N.'s

SPECIAL music, beautiful table decorations, and friendly greetings made the Council of Branches dinner at the Biennial Convention in Philadelphia a gala occasion. The guests were welcomed in behalf of the hostess organization by Mrs. R. L. Kift, chairman of the Lay Section of the Pennsylvania S.O.P.H.N. Grace Ross, president of the N.O.P.H.N., responded to her greetings. Edna Hamilton, chairman of the Council, presided at the meeting.

As usual, the dinner was small and the program informal. All but three of the 19 branches were represented and each reported on its activities for the preceding two years. Every report emphasized plans to promote lay membership and lay participation, as of paramount importance. The other activities most often mentioned were:

1. Projects undertaken by many S.O.P.H.N.'s in coöperation with State Leagues of Nursing Education to promote integration of the social and health

aspects of nursing into the basic curricula of schools of nursing.

2. Efforts to include industrial nurses in programs of branches.

3. Formation of orthopedic committees to work with local units of the National Foundation for Infantile Paralysis in planning county programs for care of the crippled.

The highlight of the evening was a brief talk by Mary S. Gardner in which she told vividly about the beginnings of the National Organization for Public Health Nursing and its state branches. Miss Gardner said that the vision and ideas of the nurses in 1912 are being realized in 1940. These founders of the N.O.P.H.N. saw the need for a service organization of lay people and nurses working together to promote public health nursing, the need for state as well as national machinery to carry out promotion plans, and the added strength which would come to all nursing through this machinery.

R.H.

Housing and Health

By C.-E. A. WINSLOW, Dr.P.H.

Bad housing is a health problem of outstanding significance, and public health as a social science is deeply concerned with the social and economic environment of people

WHAT has housing to do with health? It seems important first of all to consider what relation really exists between these two important problems of human living.

Mrs. Edith Elmer Wood, the most distinguished pioneer protagonist of better housing in the United States, has answered this question, by analogy. In a recent address in New York she said:

The Bureau of Animal Industry in the Department of Agriculture issues a long series of farmers' bulletins on the housing of livestock—dairy cattle, beef cattle, horses, sheep, hogs, and poultry. It comes out roundly with delightfully dogmatic statements, such as: "Dryness, good ventilation, and freedom from drafts are the first requisites of buildings for sheep." "If little pigs are to get the right kind of a start in life, they must have plenty of sunshine." "Growing chicks and laying hens need comfortable homes that are dry and roomy with plenty of fresh air and sunlight. It never pays to overcrowd them." Fortunate farm animals! No one writes doctors' theses to prove that there is no casual relation between their health and their housing.*

It has so far been impossible to demonstrate by exact statistical procedure what proportion of the high death rates which characterize the slums may be due to the physical characteristics of the slums themselves, what proportion are due to other aspects of the poverty of their inhabitants, and what proportion are the result of inherent physiological and psychical handicaps of the slum

dweller himself. In the absence of such data, we may profitably turn to the testimony of that rare commodity which we ironically call "common" sense.

The Committee on the Hygiene of Housing of the American Public Health Association, in its *Basic Principles of Healthful Housing*,* has listed 30 specific characteristics of housing whose direct influence upon health has not been successfully challenged.

Is it possible to doubt that rat-ridden tenements breed endemic typhus, that mosquito-breeding pools near unscreened dwellings cause malaria; that unsanitary privies, unlighted, shared toilets, polluted wells, and connections between sewerage and water supply systems promote intestinal disease; that room-overcrowding facilitates the transmission of diphtheria and scarlet fever and meningitis and pneumonia?

There are some 30,000 fatal accidents which occur each year in the home—nearly as many as are attributable to the automobile. Can it be doubted that rickety steps and rotten handrails, dark stairways, wood stoves, and kerosene lamps contribute to a substantial proportion of these fatalities?

Health, however, means more than just staying alive. Health means vigor and efficiency and satisfaction in living. The primary purpose of the home—from

*Wood, Mrs. Edith Elmer. Unpublished address on Housing, Homes, and the Family. Northeast Regional Meeting on Marriage and the Family, Hotel Roosevelt, New York City, April 13, 1940.

*American Public Health Association. *Basic Principles of Healthful Housing*. Report of the Committee on the Hygiene of Housing. The Association, 50 West 50 Street, New York, N. Y., second edition, 1939.

the cave in the Dordogne to the Fifth Avenue apartment—is shelter against the elements and the provision of an inner environment in which man can function to better advantage. The shack which has no heat in winter and the tenement which has no cross-ventilation in summer are not compatible with health. Nor is the dwelling with no sunlight by day and no adequate illumination by night. Nor the dwelling where elevated railroads or automobile horns shatter the repose of the sleeping hours.

DAMAGE TO EMOTIONAL HEALTH

Finally, we must take into account the demands of emotional as well as of physiological health. The home is a workplace where some sixty hours of labor must be performed on the average every week. If conditions are not such as to facilitate performance of the household tasks, fatigue results, as surely as in any factory workroom. Some opportunity for privacy—"a room of one's own" or its nearest possible equivalent—is an essential need for emotional health; and on the other hand, opportunities for normal exercise of the social functions is equally necessary. The Committee on the Hygiene of Housing has correctly pointed out that more damage is done to the health of the children of the United States by a sense of chronic inferiority due to the consciousness of living in sub-standard dwellings than by all the defective plumbing which those dwellings may contain.

Bad housing, as a matter of practical fact, is profoundly detrimental to health; and the existence of the slum is a health problem of outstanding significance. What can we do about it?

From the standpoint of traditional public health practice, the answer is to enforce the laws now on our statute books with regard to unsafe and unsanitary dwellings. There is ancient precedent for the exercise of such authority. At Pompeii in the year 10 B.C., even for

such a necessary public work as the city wall, built only "to the height of the tiles," the city council paid 3000 sesterces in compensation to owners of dwellings whose light was affected thereby. Some 800 years later a poor widow complained to the Byzantine Emperor, Theophilus, that the new palace of his brother-in-law, Petronas, had illegally darkened her house "so as to render it almost uninhabitable." The emperor ordered redress and when his order was disobeyed, he caused the new building to be demolished and Petronas to be flogged.

Similarly, in the reign of Queen Elizabeth, two landlords who had built and subdivided a tenement in Hog Lane for the use of poor tenants were fined and committed to the Fleet Prison. Indigent tenants occupying such substandard dwellings were specifically permitted to remain in them *without paying rent* and on the departure of such tenants the buildings were to be torn down.

NOT A NEW PROBLEM

For centuries, then, a few exceptionally bad examples of insanitary housing have been eliminated by the process of condemnation; but the total of progress accomplished has been infinitesimal in its results. The reason is extremely simple. It is quite useless to demolish substandard dwellings without providing good dwellings for their evicted populations. If all the unsafe and insanitary dwellings in any American city were condemned at once, a quarter or a fifth of the population would be camping in the streets. The provision of decent living quarters for the lower economic group at rents which that group can afford to pay is the only practical answer to the housing problem.

This is the answer which has been found by the nations of Western Europe—by England and Holland and Sweden and Denmark—for the last quarter of a century. It is the answer we

have at last reached in this country during the past five years, beginning with the purely federal policy of the Public Works Administration and now carried forward in the decentralized program of the United States Housing Authority.

THE FEDERAL PROGRAM

The actual execution of this program is in the hands of a local housing authority in each participating city or rural area. On the preparation of acceptable plans, the U.S.H.A. lends to the local housing authority 90 percent of the capital cost of land and buildings, and the other 10 percent is raised by bonds sold to private investors. Bonds covering the entire capital cost are gradually paid off by the local authority to amortise the investment in a period of sixty years. So far, the Federal Government is simply functioning as a banker, with no cost to the taxpayer.

To make reasonable rentals possible, however, the Federal Government through the U.S.H.A. contracts to pay to the local authority an annual subsidy, which at present amounts to about three fourths of the annual capital charges or about 30 percent of the total economic rent. The local community provides an additional subsidy, usually in the form of exemption from taxes or special service charges. The rent to be paid is therefore determined chiefly by maintenance, insurance, and management, and including all utilities (heat, light, and water) may be somewhere in the neighborhood of \$5 a room a month.

The families to be admitted to these projects must—at the time of admission—be living in substandard dwellings, and their family income must be not more than five times (or with large families, six times) the annual rent. Thus, the projects planned under the present law of 1938 will receive families having income varying from perhaps \$600 to \$1500 a year.

The program authorized for the

U.S.H.A. by Congress in 1937 is, of course, only a beginning. It does not provide fully for those relief families at the very bottom of the scale, except insofar as they can occupy the slightly better quarters vacated by the tenants who actually move into the new projects. It leaves out those families above the specified income level of the tenants to be admitted. We began in 1938 a program which other countries have been carrying forward for twenty-five years. There is a long road ahead; but we have at least started—and along the right lines.

Judging by the experience of western Europe and by the results of P.W.A. housing in the United States, we may expect three types of social gain from this great enterprise, upon which, as a nation, we have at last embarked.

HOMES, NEIGHBORHOODS, CITIES

First, a considerable group of individual families now living in substandard slum dwellings will be removed to well planned row houses and apartments that "will not fall down and will not burn up," with sunlight and adequate heat in winter, with fresh air in summer, free from overcrowding, well lighted by day and by night, equipped with adequate facilities for cooking and refrigeration, with play space for young children and in a setting sufficiently attractive to promote self-respect and satisfaction. For the first time in our history homes are being built for the poor—not to be sold or rented to them but to be lived in, with efficiency and economy. And this is being done on a large scale and with the counsel of the very best engineering and architectural and social and health experts in the land.

These homes are, furthermore, not simply individual dwellings. They are parts of well ordered projects where groups of some hundreds of families live in a community, with common indoor and outdoor recreation space, with mutual interests, with a sense of belonging

to a well ordered and self-respecting community. The re-creation of the neighborhood spirit in the modern city is one of the most essential needs of democracy; for the isolated individual falls a helpless prey to the voice of the demagogue or the dictator over the loud speaker. Housing builds not only homes but neighborhoods.

It may do even more than this—it may build cities as well. Our cities are sick today, victims of the slum sickness. We rightly speak of "blighted areas"; for the slum like the blight on a plant or the cancer in the human body poisons the area around and spreads like a progressive malignant disease. Year after year deterioration in property values spreads outward from such a center. The city dies at its core and its more prosperous residents move out into the suburbs and carry their taxable values with them. But good things are contagious as well as bad. From well designed public housing projects there radiates an extending influence which enlists the power of private capital to build similar modern dwellings for higher income levels. In England, for every home built at government expense two new homes have been constructed by private enterprise; and one can see the same process already beginning in Washington and other American cities. The housing program may yet prove the salvation of our urban communities.

This discussion has ranged far afield from the traditional interests and objectives of public health nursing. It is symptomatic of a new era in public health—one example of a host of new problems which require a realignment of our forces and a broadening of our vision. The board member group has shown so keen an imagination and so high a leadership in the past that I hope and believe it will rise to the challenge of the future.

In the period before 1910, the public health campaign was concerned chiefly

with the physical environment of man, with polluted water and insanitation, with the acute communicable diseases and protection against those diseases by isolation and quarantine and immunization. It was chiefly defensive and its weapons were those of the engineer and the bacteriologist.

CHANGES IN EMPHASIS

At the end of the first decade of the present century, a radically new emphasis began to dominate the public health program—an emphasis transferred from the physical environment to the human body itself. The pioneers of the fight against tuberculosis were, it is true, interested in the isolation of the open case and the disinfection of sputum; but they were even more interested in the diagnosis of early symptoms of disease and the upbuilding of vital resistance by the practice of personal hygiene. The program for reduction of infant mortality included the sanitation of milk supplies; but it gave a more prominent place to the examination of the individual infant and the training of the mother in the hygiene of feeding and bathing and airing and clothing. In the past thirty years—as mass epidemics of the herd have come under control—the health of the individual has become a paramount concern. Public health today is not merely an engineering science, as it was in the nineteenth century, but primarily a medical science.

In this fundamental transformation, public health nursing played a major role. It was the change of the visiting nurse to a public health nurse, about 1910, that established the first effective link between a planned community health program and the individual family in the home. For what the nursing profession has accomplished and for the leadership of the board member group in that accomplishment, we owe an incalculable debt of gratitude.

Today, however, the health officer and

the nurse must meet a new challenge, must acquire a new field of broadening vision as significant and revolutionary in its scope as the sea change which took place in 1910. Thirty years ago, our major emphasis was transferred from the physical environment to the individual. Today, we must shift our gaze from the individual back to the environment, but in a broader sense than that of 1910—to the whole social and economic environment in which the individual lives and moves and has his being. The public health of the future must be not only an engineering science and a medical science. It must also be a social science.

Let me go back for a moment to the beginnings of the modern public health movement which took place in England a hundred years ago. This movement was not initiated by an engineer or a physician but by what we should today call a social worker—Edwin Chadwick, secretary to the poor law commissioners. Chadwick, in his classic report on *The Sanitary Condition of the Labouring Population of Great Britain*, published in 1842, awakened England and later the civilized world to the menace of the insanitary environments which bred the plagues of cholera and typhus fever in the crowded slums and the filthy villages of the time. These gross conditions of insanitation have been corrected and the plagues and pestilences of the Middle Ages have disappeared.

OUR PROBLEMS TODAY

Today, however, it is still true that mortality rates in any given community steadily rise as we pass down the economic scale. Lack of medical care, defective nutrition, insanitary housing, social insecurity—these are the major health problems of today, as dung heaps were in 1840 and germs in 1890. We need a Report on the *Economic Condition of the Labouring Population*—and of the population unable to labor on account of social dislocation—in the

United States, as a contemporary equivalent of Chadwick's report of 1842.

We know that such a report would show at present nearly one third of the families of this nation attempting to live on family incomes of \$800 or less; and we know, beyond peradventure, that such incomes as this cannot purchase the food and the housing and the medical care necessary for the maintenance of health.

During the past eight years, we in the United States have at last attacked this major problem of poverty in an effective way. We have initiated a housing program which, if continued, will eliminate the slum and give the underprivileged simple but decent and sanitary homes. We have developed the framework of legislation for unemployment and old-age insurance which limits to some extent the menace of insecurity that plays so vital a role in the field of emotional health. We are about to establish a national commission on nutrition which can stimulate planning in this vital area of health and welfare. We have before Congress—though still buried in committee—a measure designed to make the precious gifts of modern medical science available for the great groups to whom they are now denied.

What these measures which we are tardily initiating may mean for the health of the American people, we may learn from experience abroad. The *London Times* last June furnished the following testimony. This reasonably conservative organ of opinion said in effect:

An unsolicited testimonial to the vast improvement in the health of the people during the past twenty years is contributed by the medical examinations of the young men of 20-21 now coming forward under the Military Training Act. During the period June 8 to June 12 the percentage absolutely rejected was only 2.3. Of the remainder no less than 84.5 percent were placed in the highest grade. As compared with the figures in the Great War these are almost startling. We seemed in danger then of becoming a C3 nation. Today C3 is down to 2.3 percent. To what is it due?

Higher wages, better housing, better sanitation, better feeding, better scope for athletics, babies' welfare, school medical inspection, national health insurance with medical treatment. Those things represent a definite scheme of coordinated public care—the "social services" which the state in Great Britain has been actively developing for rather over thirty years. We are often told about the vast cost of these services; and indeed their place in the national budget is a spectacular one. It is a good thing now to have a clear reminder of the other side of the account, and be shown the money's worth that we have got for our money. The advance is indeed marvelous.

Such is the record of democratic planning for the good life, in England, in Holland, in Denmark, in Norway, in Sweden. Similar achievements were accomplished in democratic Germany prior to 1933. Today, the brilliant promise of western Europe is threatened with extinction. A new ideology of force and violence and hate endangers all the ideals of civilization and Christianity. Denmark and Norway are gone and England and France are fighting with their backs to the wall. This is not the place to discuss whether we in the United States have any vital interest in the conflict. This, however, we can say—that we have the obligation to see that the ideals of the best of western Europe shall not perish from the earth if we can realize them here.

The seal of my state of Connecticut bears the symbol of three seedlings and

the motto "*Qui transtulit sustinet*," "He who transplants must sustain." It is our challenge to foster the great vision of "life, liberty, and the pursuit of happiness," of equal opportunity, of the good life for all, attained by the democratic process of mutual consent. It will not be easy. These problems are much more difficult than those which confronted public health in the past. The diphtheria germ had no friends; but the insanitary tenement and the unrestricted competitive system in medicine have powerful allies. There are dark forces of selfishness in every soul. As Artemus Ward said, "There is a great deal of human nature in man."

But human nature has resources of good as well as of evil. If we appeal to the forces of mutual good will, if we keep to the ideal of mutual service, if we recognize that individual life, liberty, and happiness are attainable only through intelligent mutual cooperation we can control the evils of poverty as we have controlled the menace of germ diseases—and we can fulfill what the founding fathers of this republic conceived as its peculiar contribution to the history of mankind.

Presented before the N.O.P.H.N. dinner sponsored by the Board and Committee Members' Section, Biennial Convention, Philadelphia, Pennsylvania, May 15, 1940.

THE AMERICAN JOURNAL OF NURSING FOR JULY

An Independent Estimate of Nursing in Our Times.....	Alan Gregg, M.D.
The Thyroid Patient.....	Charles W. Mayo, M.D. and Joseph M. Miller, M.D.
Nursing Care of the Thyroid Patient.....	Myrl I. Peterson, R.N.
Nursing in Mexico.....	Mary Colby-Monteith, R.N.
Character Education.....	F. Ernest Johnson, D.D.
"New" Drugs.....	Mayo E. Soley, M.D. and Alice E. Ingmire, R.N.
Obstetric Nursing Experience.....	Mary E. Benton, R.N.
Nursing in a Trailer.....	Myrtle W. Martin, R.N.
Principles of Supervision in Nursing.....	Anna M. Taylor, R.N.
Supervision and Teaching—Free and Inexpensive Materials	

Nurse Placement Service



announces the following placements from among appointments made in the various fields of public health nursing. As is our custom, consent to publish these has been secured in each case from both nurse and employer.

- *Virginia Jones, Instructor in Public Health Nursing, University of Hawaii, Honolulu, T. H.
- Kay Braverman, Consultant in Orthopedic Nursing, State Child Welfare Division, Services for Crippled Children, Lincoln, Nebr.
- *Mrs. Mary duFlon, County Nurse, State Department of Health, Portales, N. M.
- *Mrs. Mary Hitchcock, County Nurse, Torrence County Health Department, Estancia, N. M.
- *Eugenia Evanoff, County Nurse, Rio Arriba County Health Department, Tierra Amarilla, N. M.
- *Margaret Howe, County Nurse, State Department of Health, Springfield, Ill.
- Margaret Patterson, Staff Nurse, Seattle Visiting Nurse Service, Seattle, Wash.
- *Ruth Dahlgren, Staff Nurse, Iron County Health Department, Stambaugh, Mich.

ASSISTED PLACEMENTS

- *Beatrice Nichols, Community Nurse, Community Nurse Association, Glendale, Ohio.
- *Emma Lois Shaffer, Staff Nurse, State Department of Health, Albany, N. Y.

The foregoing list represents only a part of the interesting placements made, since N.P.S. has not received in every case—for one reason or another—the consents for publication from both employers and nurses.

Miss Tittman, Mrs. Ruth Olson, and

*The N.O.P.H.N. files show that this nurse is a 1940 member.

Florence E. Spaulding were happy to greet so very many of their old and new acquaintances among the nurses and employers in attendance at the Biennial Convention. They take this opportunity to express regret that time was not elastic enough to enable them to see all who called upon them at their attractive branch-office booth. Three hundred and forty-nine interviews were held. As one nurse remarked, "It's the busiest booth at the convention except the booths where free drinks are being dispensed."

Prospective conventions where Miss Tittman will be available for interviews are:

September 16-20, American Hospital Association, Boston, Mass.

October 8-11, American Public Health Association, Detroit, Mich.

There is the usual summer rise of open jobs of all types at N.P.S. office, to be filled by fall. An unusually large number of excellent school nursing positions is being listed at this time.

In May Miss Mackenzie went to Marquette University on a speaking and interviewing visit. N.P.S. had booths at the Midwest Safety Conference and the Tri-State Hospital Assembly, both in Chicago, and Miss Tittman spoke at the latter meeting on "Wanted—A Nurse-Anesthetist." Miss Tittman also spoke at a banquet in Rockford, Illinois, when the Third District, Illinois State Nurses' Association entertained all of the graduating classes from nursing schools of the area.

ANNA L. TITTMAN, R.N.
Executive Director

Tuberculosis Case-Finding in Industry

By CHARLES-FRANCIS LONG, M.D.*

An industrial physician evaluates various methods of tuberculosis case-finding in relation to their diagnostic accuracy and practicability in industry

TUBERCULOSIS case-finding in industry stands to industrial medicine in the same relationship as gasoline stands to oil. It is a byproduct which has assumed almost as great an importance as the parent substance. Every physician who is responsible for an adequate program of industrial health in any business establishment is automatically enlisting and aiding in the campaign against tuberculosis; yet he is doing so only by secondary intention. His primary intention is to secure to each individual worker the best possible health within the limitations of that worker's body and mind. The physician accomplishes this end by means of pre-employment, periodic health, and return-from-illness physical examinations. Applying these techniques to any population group is bound to result in the discovery of pulmonary tuberculosis in a certain number of individuals. And naturally, the more thorough the examination, the more cases of tuberculosis discovered.

Besides the interest which every practicing physician evinces in the problem of tuberculosis, we who serve in industry have our problems multiplied by this disease. The studies of Louis I. Dublin from 1911 through 1935 have put us on our mettle. Of general industry he said: "The death rates for tuberculosis, age period for age period, are from two and one-half to nearly four times as high

among the industrial workers as among the professional, mercantile, and agricultural group."¹

Reading these figures, one would have cause for concern; and added to these sources of worry, we have the now legally recognized association between silicosis and pulmonary tuberculosis. Finally, there is the relationship between chest trauma and self re-infection from spilled cavity contents, or the rupture of a none too well healed lesion.

So we are very much interested in finding the tuberculous applicant for work, as well as the unfortunate who breaks down a healed lesion while working, for they both may constitute foci for the spread of the disease within the plant.

But case-finding in industry differs from case-finding in private practice or in the tuberculosis clinic, and the essence of the difference can be expressed in the two words *time* and *money*. In private practice the patient comes to his physician's office prepared to spend an unlimited time on examinations and tests. If the tests cannot be completed in one day, the next day and the next do just as well. Various physicians may be visited in the course of the complete physical examination. A clinic must work a little faster. It has certain hours within which a certain number of people must be seen, and a certain amount of work must be accomplished. A large hospital clinic is a busy place with its 25 to 50 patients waiting for their examinations.

* Dr. Long is medical director of Bayuk Cigars Inc., Philadelphia, Pennsylvania.

But consider now how much busier is the modern industrial dispensary with its hundreds and even thousands of employees waiting their turn for examination on a definite time schedule. And not waiting their turn as you and I see them in a doctor's office or in the clinic—with that particular morning or afternoon set aside just for the purpose of consulting a physician—but waiting their turn as they come from the machine, the employee knowing and the physician knowing that every minute spent unnecessarily represents a definitely calculable loss of money.

So we physicians who serve in industry have developed routine physical examination techniques that will yield the greatest amount of health information for the shortest amount of time expended, and since pulmonary tuberculosis is one of the diseases with which we have to deal, we have applied this same philosophy to examination of the lungs. No test can be of use that requires too much time in the doing or expends money out of proportion to the results obtained. And by "results obtained" most people mean, "How many cases of tuberculosis did you discover per hundred examined?" and "What was the discovery cost per case?"

This factor of money costs is of deciding importance in any tuberculosis discussion, and Plunkett has well said, "A case-finding program which will discover the maximum number of cases of tuberculosis for the dollars expended is one of the important elements of a plan for the eventual control of tuberculosis."² He detailed a study in which 349 cases of pulmonary tuberculosis were discovered among 11,928 examined, at an average cost of \$171. In this group it cost only \$67 to discover a case in adults over 45, as compared to \$4419 per case in children of 15 and under. However, the average cost per individual was \$5, but the sole result

was the discovery of or failure to find tuberculosis.³

If costs were as staggering as this in industrial health examinations, none would be done. In industry we must husband our money a little better. It is a fair estimate that the top cost for adequate health service to industry is \$10 per employee per year. This includes all medical expenditures of whatever nature, excepting compensation payments for industrial accidents, which must be regarded as insurance costs. This figure does include tuberculosis case-finding; so you see we must choose a technique for case-finding that will yield the largest results per unit of time and money expended, without sacrificing diagnostic accuracy. It is important to understand that diagnostic accuracy is the one thing we refuse to surrender for reasons of either time or money.

TECHNIQUES OF CASE-FINDING

What are the techniques of case-finding from which the industrial physician must select the most adaptable, and what are the reasons for his selection?

Physical examination

First, there are the ordinary methods of physical examination by means of eyes, hands, and stethoscope. A decade ago I taught physical diagnosis of the chest at the University of Pennsylvania. It was my custom to warn my classes that the man who waited to hear rales in the lungs was at least six months behind the lesion. Today I would rectify that statement and agree with Sawyer that the stethoscope is an almost obsolete instrument in the discovery of incipient tuberculosis,⁴ which is the only form that good preventive medicine should allow to occur! So the usual methods of physical examination are entirely inadequate to case-finding in industry.

Tuberculin test

Next we must consider the tuberculin

test. This reaction will be positive if there be a tuberculous focus within the body, regardless of activity or healing, and no matter where that focus may be situated. But the working population are adults who in childhood have met and conquered the tubercle bacillus, and carry the evidences of that victory in the form of healed lesions. Consequently, in the majority the tuberculin test will react positively. These positive reactors must then be x-rayed, and so we have increased our technical difficulties without aiding our diagnostic accuracy. We therefore cannot use the tuberculin test.

Sputum examination

Third, the examination of sputum for Koch's bacilli is mentioned only to remind us that a positive sputum cannot be obtained from the minimal case, and again we insist that this is the case in which the industrial health worker is most interested. Our chance has passed us by when we find a sputum laden with bacilli and we must send the patient away for many months, or for years. We want to find tuberculosis as near its inception as possible. We want to be able to say to our tuberculous employee, "Go home to your family doctor and he will tell you what to do for this lung trouble of yours. Do exactly as he tells you and you will be cured and working again within six months." We want to feel that that employee will be back on his own job again, and that before he left our employ he did not have much opportunity to infect his fellow workers. Obviously, then, sputum analysis is of no help to us.

Stereoscopic celluloid lung films

Fourth, a few fortunate companies use stereoscopic celluloid lung films, and these are by far the most ideal media for case-finding. The reason I use the phrase "fortunate companies" is because of the prohibitive cost of these films in ordinary industrial work. If we at-

tempted to survey our 4600 employees in this manner, the lowest cost would be \$9200 at absolutely bargain rates, or \$23,000 at a fair minimum rate. Then, too, the time factor enters again. It would be no simple task to stereo-film and diagnose 4600 chests in a working year of 300 days. So although this is the ideal method theoretically, practically its use must be reserved for checking those lungs that another more rapid and less costly technique has discovered.

If the industrial physician rejects all the above techniques, what can he use? There are two methods left that have the common denominator of speed and economy—paper film and the fluoroscope.

Fluoroscope

My personal preference is for the fluoroscope. It enables us in a minimum amount of time to view the lungs in all phases of respiration and from all possible angles. We follow the technique of Fellows and Reid which has been developed so successfully in dealing with the employees of the Metropolitan Life Insurance Company. To the trained observer small lesions are visible in the fluoroscope, but even more important for early diagnosis are the deviations from normal respiratory function that may be seen. But we use this instrument with the definite philosophy that it is merely a sieve or screen with which to separate possibly affected lungs from those that are clear. I must keep telling myself just as I am telling you, that the fluoroscope is not a diagnostic machine but only an assay method, and that the court of final diagnostic appeal is a set of stereoscopic films of those lungs, interpreted by an experienced observer.

The fluoroscope answers our purpose twofold. First, because of the minimum financial outlay involved. It costs about the same as a low priced car and its maintenance and operation costs are very small. Second, it answers the

other problem concerned with mass examinations, that of speed. An examination can be completed in two to five minutes, keeping the employee away from the machine only a short time.

But as with all good things, it has its drawbacks. When we use the fluoroscope we have no permanent record other than the dictated interpretation of the observer. Recently, however, it seems that a well known electric company, after several years of research, has come to our assistance in this difficulty. Its staff have perfected for us a means of photographing the image on the fluoroscopic screen. The finished picture is 4 inches by 5 inches, an excellent size to be filed with the employee's record. These films are interpreted by using a glorified magnifying glass. Those who have worked with them give glowing reports of diagnostic accuracy; so we may hope this photographic process will remove many of our difficulties and further the obvious advantages of the fluoroscope.

X-rays on paper films

Finally, as a diagnostic medium we have x-rays of the chest done on rolls of *paper* film. The cost is relatively low—75 cents apiece. The speed is remarkable—500 can be taken a day and 30 to 40 interpreted an hour. Only a few industries have adopted this method, and the apparatus must be *rented* from a commercial x-ray company. But the results of its use in mass surveys as a *screening* method have been excellent, as can be attested by the C.C.C. medical

services, the studies of Edwards and Barnard in the New York City Department of Health, and the university health services headed by Arnett and Lees in Philadelphia.

But all that I have told you so far concerns the doctor's part in tuberculosis case-finding in industry. You, as industrial nurses, have an equally important part to play. You meet the employee first in industry, and so yours is a job which requires tact and winning the patient's confidence. We both know that the time to discover pulmonary tuberculosis is when the patient is apparently well. But the employee who feels well and is about to have a lung x-ray picture is full of fears which are understandable.

You can greatly help in overcoming this psychology. Point out that even if something is found, it is only a small shadow. And how fortunate to find it early before any real damage has been done! In the girls who visit your industrial dispensary, keep a close watch on loss of weight, mild pallor, and complaints of fatigue. Remember it's better to x-ray ten chests and find nothing than to miss the one showing an early lesion. If we apply properly the methods I have outlined, we can completely eradicate pulmonary tuberculosis from the working world.

Presented before the N.O.P.H.N. Round Table on Tuberculosis in Industry, Biennial Convention, Philadelphia, Pennsylvania, May 13, 1940.

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Leadership Through Supervision

By VIRGINIA P. ROBINSON

The supervisor in a social-work or nursing agency is concerned with the worker's job-performance and the continuous development of her professional self

SINCE public health nursing and social work have much in common in their ideals, their goals, and their purposes, a philosophy of supervision developed in one of these fields may be useful in the other. Both fields of endeavor exist in order to render services to people who need them. Public health nursing has the more definite, tangible, and essential service to offer. For in the life of every individual and every family and every community, health needs are fundamental and health services are understood and accepted. Social services, with perhaps the single exception of relief for economic need, are more intangible, more difficult to interpret.

If we disregard the content of the services and consider the bedrock of what we are trying to do in social work and in public health nursing, it seems to me we are attempting to do the same thing. We are trying to offer services to people who are in desperate need of them, but who often have great difficulty in finding out where the services can be found or in using them when they do find them. We have the same problems—problems intrinsically related to the nature and the meaning of service of any kind. For service is not a commodity—solid, substantial, and obvious, but a value—delicate, intangible, elusive. A commodity can achieve its own intrinsic, objective quality; a service, on the other hand, must depend for its quality on the way it is used as well as the way it is offered. A commodity can be paid

for and the transaction is over. But the essence of real service, whether paid or free, lies in the value which transcends that which can be adequately paid for. The recipient can pay for such service only in feeling (gratitude) and in the use to which he puts this value as he makes it his own.

TASK IN COMMON

Public health nursing and social work have this very difficult task in common—to learn how to offer a service so that it can be taken and used by those in need of it. Perhaps social case work has become more aware of this as its essential task earlier than public health nursing because of the difference in the tangibility of the services offered. Nurses have so much to offer: In health knowledge, in nursing skill, in tangible things which the patient can take and hold in his hand—diets, codliver oil, thermometer, pamphlets. Their knowledge and skill are guaranteed in their nursing education which precedes their public health work. All this equipment may easily obscure the recognition that the service is effective only as the other person can take and make use of it. Social case workers with nothing *but* service to offer in some situations have been forced more quickly to the painful realization that all their knowledge and skill count as nothing unless the other person wants to use it and unless they can discover the secret of a skill that will help him use it.

This comprehension of the human

and psychological nature of service, the conviction that its value and effectiveness depend upon the way it is offered and the way it is taken, places upon the shoulders of the individual practitioner in a service agency, whether health or social, a truly professional responsibility. As she represents the service of her agency in the community, the usefulness of the agency stands or falls by her capacity to accept that responsibility and develop the individual skill it requires to give a service to clients.

BOTH OPERATE UNDER AGENCIES

In one other respect social work and public health nursing resemble each other in a way that has an important bearing on the developments of supervision in these two fields. In both fields the individual practitioner, in spite of the degree of responsibility she carries, operates never as an individual but always as a staff member, the representative of an agency—voluntary or official. It is in the agency that the meaning of the service inheres primarily. Private philanthropic agencies supported by volunteer giving, such as the charity organization society, the visiting nurse society, the children's aid society, and the child health society, have carried the ideal and meaning of service in the community through the past century.

Today, reaching far beyond the resources and capacities of the privately supported organizations, government is assuming responsibility for extending health and social services to meet the needs of the community. In government bureaus and private philanthropic agencies alike, the value and the effectiveness of the service rest at bottom on the skill of the individual health or social worker in meeting her patient or her client and helping him to make use of the service of the agency.

But the way the agency works together as a whole in its comprehension of the meaning of its service to its

clients and to every worker on the staff determines to a large extent what the practitioner will have to put into the contact with client and community. For the practitioner, this connection with agency is both support and limitation in the development of professional responsibility and skill. To understand where and how individual skill operates, to know what structures to put into the agency in order to favor and encourage its development, to know what rules and procedures to lay down to support and limit individual skill and relate it to the agency as a whole—these constitute challenging problems for administration in a service agency.

MEANING OF SUPERVISION

The discovery of supervision on the part of the social and health agencies as a solution for this problem of developing individual skill and training it to operate in relation to the agency as a whole, amounts to as great a discovery in the development of such agencies as did the invention of the machine for industry.

It is unfortunate that the word *supervision* derives from industry where its commonly accepted meaning is a watching over or checking on the part of someone responsible for the work of another person. In industry, a foreman is responsible for the quantity and quality of output in the manufacture of commodities. He supervises, oversees, and inspects the operations of his machines and his men. Progress in industry has come through the introduction of machines and the gearing of men to play their small part in feeding raw material into them and directing the product from one machine to another. The machine sets the speed and the type and the standard for the operation of the whole. Once they are installed and the men have learned to use them, the function of the supervisor can be well described by the words *inspection* and *checking*.

In organizations which exist to create and offer services, on the other hand, the place and the role of the supervisor are entirely different. The supervisor occupies the key place in a service agency that the machine occupies in industry. She must contain the service of her agency in herself and understand it in its finest aspects. She must be in possession of the skill that can offer it so that people can make use of it. She stands between the administrative head of the agency—where the goals of service are stated and the plans for attaining them mapped out, where procedures are set up to facilitate the flow of services and the relationship of the parts of the organization to each other—and the individual staff workers on whose activity depends the essential success or failure of the organization in offering service to the community.

What is asked of a supervisor here is so different from and so much more than what is asked in an industrial plant that it is a pity the same word should be used to describe it. There is no one word in the English language that can adequately describe the role of the supervisor in a service agency, for the reason that a new way of functioning is being created here as new in human experience as was the machine in industrial experience when first introduced. By this it is not implied that supervision has not been ably carried in many fields of activity again and again by people who had it in them to do what is required. What is new in the past decade is the effort to describe and analyze the skills required of a supervisor and to develop those skills consciously in a training process.

IS SUPERVISION TEACHING?

In seeking words to describe supervision in a service agency we define it as teaching, again falling back on a word which has been given content by usage in another field. If we think of teaching

as what goes on in most classrooms between teacher and pupil, we fail completely to understand what is asked of a supervisor in a public health or social agency when a new worker comes to her to learn how to function as a member of that organization. She may come straight from the best school of nursing in the country. She may have had some months of experience in a public health nursing agency, as part of her preparation. She may even have had a nine-months' public health nursing course with field work in several training centers. But she comes to your organization new to your service, new to your community. She may have to learn how to work in the poorly equipped home instead of in the orderly hospital. She has to work with less dependence on the doctor and more on herself. She has to learn to work with other nurses in a different way and with many other people in the community in new ways. The environment in which she must operate and the services she is to offer are so different that she may feel she has to make herself over completely.

No matter how carefully health has been integrated into her preparation, the nurse who turns from nursing the sick to offering public health service in a community by this decision allies herself with health rather than sickness. She must relate herself to strength as well as to weakness. She must approach people to help them help themselves. It is easy to say these words but the actual process is so difficult, requiring such a sensitive consideration of the other person, such a skillful use of oneself in the other person's behalf that many people make no success of it at all.

NOT EXACTLY ADMINISTRATION

The supervisor who undertakes to help the new staff member accomplish this shift in her orientation, develop professional skill in helping people, and find her place in the total organization

of the agency knows that what she is attempting to do is different from administration, though part of what she does falls under this head; and that it is different from teaching, though some of her activity with her workers can be properly described by this word. The new worker as she tries to take on the function of the agency with its strange ways, rules, and procedures, assigned to a supervisor who knows the agency's service and setup and who stands to her for the agency as a whole, is aware, too, that this supervisory relationship offers something different from what any classroom has offered. She will know by the same token that something totally different is expected of her in using supervision here.

WHAT, THEN, IS SUPERVISION?

There is no name which brings out the essential characteristic of supervision, distinguishing it from administration and teaching. We can only make this difference clear to ourselves in practice and in a description of practice.

Social case-work practice, for the very reason that it has had a less tangible service to offer than public health nursing, has been forced to define the meaning of service and to examine more intensively what is involved in skill in offering service. We have distinguished it clearly from knowledge, to which it is obviously related. Knowledge about family problems—economic, social, psychological, and health—is not enough to insure that a family can make any use of that worker's knowledge unless the worker knows *how* to make herself available for use. In the same way, social case work has analyzed supervisory practice, distinguished it from knowledge about health and nursing and agency and community, and described the skill which the supervisor must have if she is to develop skill in the worker and be helpful in relating this skill to agency and community.

Three points have been selected to bring out the most essential factors on which good supervisory practice rests in social case work. Because they derive from an understanding of what skill is in a service agency and how it may be developed, these factors are fundamental in good supervisory practice in any service agency. But its application differs in different fields and different services and different agencies. So these factors will be stated abstractly and the reader left to make any application he can to his own practice.

ORIENTATION OF SUPERVISOR

The first point concerns the orientation and attitude of the supervisor. It is taken for granted that a supervisor is in possession of the skill which is necessary to offer the service of her agency to clients. No one can teach or pass on to another person that which they do not have themselves. But the supervisor must accept for herself the fact that in order to help her worker acquire skill, she must forego her own direct relation to the client and let her worker have it. She must realize that she is dependent on her worker for all she knows about the client and that only as her worker is able to relate herself helpfully to the client can any good come out of the agency contact for him.

A young supervisor who has just moved into supervision from a position as staff worker where she has learned to carry her own case load with a conviction that she was really giving service to her people has a painful adjustment to make in giving up those cases and supervising the new worker who takes them over. She will feel that the new worker operates too fast or too slowly; she does not understand one client; she is too sympathetic or too easily taken in by another.

As long as the supervisor has this attitude, nothing helpful can happen in supervision. This constitutes the first

discipline she must undergo in her training in a new skill. She must give up her own desire to do it herself and let the worker get hold of the case in her own way. When the supervisor succeeds in doing this she may make it possible for the worker to bring the problem to her so that she can see the worker's activity in it as well as the client's. At that point she begins to supervise.

SUPERVISOR WORKS THROUGH WORKER

There are always three centers of force in a supervisory relationship: the supervisor, the worker, and the client. Add to that, of course, the fact that the client is a center of a complex of forces in family and community relationships. The supervisor must know that her control over these forces in client and community is an indirect one, effective only as she learns how to relate to her worker effectively in conference. The staff worker as she moves into a family or a situation is the new dynamic which has the power to produce movement and change in that situation. If the supervisor has conviction about this and sticks to it she can help the worker see what she is doing and do it more skillfully. Whenever the supervisor loses her sense of this and goes in to do something herself she runs the risk of dissipating the worker's strength and confusing all the issues.

GROWTH OF PROFESSIONAL SELF

This may seem to go against many things that are good practice in public health nursing—the use of demonstration in supervising, for example. The demonstration of a technique to a nurse or group of nurses in clinic or classroom or home situation seems an excellent way of teaching in general terms. But the supervisor's next and more different step in teaching lies in leaving the nurse free to apply this technique in a way that has to be her own. Her application of it must deviate from the standard technique in some way as every nurse

is different from every other and as every individual and family are different from every other in the way they make use of it.

If you ask the staff nurse to use professional skill and to carry professional responsibility for her own judgment, you must learn how to leave her free to develop them under supervision. The supervisor either has to develop a relationship with her nurse which gives her confidence in that nurse's technique and judgment and releases the nurse to make use of the supervisor when she needs her; or if the supervisor believes only in her own capacity to do it right and cannot learn how to leave it to the nurse, she must follow every nurse into every home to check on her performance.

If the supervisor is clearly orientated to her function of *helping* the worker—not *doing* it for her—the worker becomes the true center of the supervisory process. She struggles against being this center, against taking the amount of responsibility it puts on her, and against the agency controls which limit the expression of her activity. Only the supervisor's integrity; her identification with all the factors in the situation; her understanding of agency function and regulations, of the client's needs and idiosyncrasies, of the worker's problems in dealing with client and subjecting herself to regulation—only these enable her to go along with the worker's struggle, supporting and limiting it until it eventuates in professional skill that can assume its own responsibility.

THE CONFERENCE HOUR

The second point in developing supervision concerns the structure within which the supervisory process is carried. Just as the office interview or the home visit is the unit out of which grows the service or treatment relationship with the client or patient, and the class hour is the unit of the learning process between the teacher and student, so the

conference hour is used as the unit within which the supervisory process develops. We have found it important to set it up as clearly and definitely as a class hour so that supervisor and worker can count on it. If a conference is held regularly every week by a supervisor who understands this learning-teaching relationship as a psychological growth process developing in time, stimulated by time limitations, the conference hour will come to have body, texture, and meaning. And each conference will be related to the next through the continuity of a moving process.

The content of the conference hour covers the whole range of the worker's job as she brings it to the supervisor and everything the supervisor must bring to the worker in regard to administrative regulations that control that job. We have learned that conferences cannot run along smoothly and pleasantly but that there must be confusion, bewilderment, struggle, and sometimes hard feeling expressed before the worker can get hold of her end of the job and begin to develop her own skill. The supervisor must be as free to inject criticism when it is needed as she is to give deserved praise. And there must be criticism of every worker's performance no matter how good it is if she is to develop beyond her present level to better use of herself. Criticism is hard to give and hard to take so that something constructive comes out of it. Perhaps the supervisory and the teaching relationships are the only relationships which permit criticism to be given and taken without hurt.

EVALUATION A JOINT PROCESS

In this supervisory relationship it is important always to keep clearly in mind that we as supervisors are concerned with the worker's job-performance and the development of her professional self and never with her personal self except where it is involved with her professional

use of herself. This limitation accepted by the supervisor is the only thing that makes it possible for her to carry the most difficult and responsible of all her functions, that of evaluation.

And this is the third and last point to be made about supervisory practice. Evaluation requires that the supervisor stand off and look at her worker with whom she has had a meaningful supervisory relationship and judge how far she has come, what she has learned, and what still lies ahead. There are some workers of whom she must say: This one can never learn to work with me and with the client helpfully; she is careless, wooden, inflexible, or punishing. Of another, she must say: She has learned to work with me so well I think it is time for her to get an experience in another district with another supervisor. Of another, the supervisor may have to judge whether she is ready to become a supervisor herself.

I know very few supervisors who are comfortable with this function of evaluation. But in social case-work agencies we have found great value for workers in periodic evaluations which make it possible for them to get hold of where they stand in the job and in the development of their own performance and capacities, and which serve as points of change around which they organize themselves to move to a new level of skill. If the supervisor once sees the constructive use a worker can make of an evaluation when both supervisor and worker participate in it, she becomes converted to its usefulness as a tool in supervision.

TEST OF SUCCESS

In conclusion, it is important to recognize that the concept and practice of supervision presented here can be sustained only in an organization which functions as an organic unity, set up and administered with consideration for the relation of every part to the whole.

In an organization of this sort every staff member participates from his own functional position. There is constant change and movement, with increasing understanding of service, growth in skill, and changes in position and function of staff members. Change will be handled by participation and not by pressure and counter-pressure; quality of service, not efficiency, will be the test of its

success. Such an organization will never be free from problems, conflict, and struggle. For by constitution and purpose it is dynamic—not machine-like and static—and therefore as real, as alive, and as human as the service it offers and the community it serves.

Presented before the N.O.P.H.N. General Session, Biennial Convention, Philadelphia, Pennsylvania, May 17, 1940.

Membership Rally a Lively Event

FOR N.O.P.H.N. members and friends, the gayest event in the Biennial Convention was the Membership Rally luncheon in the ballroom of the Hotel Bellevue-Stratford on Tuesday, May 14. Here over five hundred nurses and board members gathered for an informal hour of camaraderie and recreation midway in the week of meetings and conferences. Attached to the programs were souvenirs in the form of key rings with a charm—the N.O.P.H.N. seal.

At the long speakers' table sat the membership chairmen from 18 states; Amelia Grant, chairman of the National Membership Committee; Grace Ross, president of the N.O.P.H.N.; and our beloved Mary Gardner, guest speaker. The audience was entertained during luncheon by accordion music played by Robert Foster.

A spirit of hilarity characterized the program, which began with a group of rollicking songs on the N.O.P.H.N. by a quartette composed of the following members: Clementine Elliott, staff nurse in the New York City Department of Health; Rena Haig, chief, Public Health Nursing Service, California State Department of Public Health; and Alice F. Guiney and Mrs. Sara Gessleman,

staff nurses in the Babies Hospital of Philadelphia. The accompanist was Kathryn O'Boyle of Philadelphia.

The response to the roll call by Amelia Grant showed a representation from all the states but two, and from Alaska, Hawaii, Puerto Rico, and Canada.

"Public Speaking with a Hazy Glow" was the subject of an entertaining address by Mary S. Gardner—known to public health nurses everywhere as the author of the book *Public Health Nursing*. The audience rocked with laughter as Miss Gardner in her own inimitable way warned them that the successful speaker avoids giving facts which may have to be defended or verified and endeavors to produce in his hearers a satisfying feeling of hazy glow.

Five membership chairmen then participated in an animated discussion on various "problems" in public health nursing. This turned out to be a parody on the practice of exchanging professional experience and ideas. They talked "of many things"—not ships and sealing wax and kings, but the use of aeroplanes for transporting rural nurses, the best way to keep public health nurses from marrying, and a technique for filing chewing gum according to flavor on a

varicolored necklace to be worn over the uniform. Engaging in this repartee were: Ann S. Nyquist, Minnesota; Ruth C. M. Anderson, Rhode Island; Cynthia L. Sweet, New York; Irene de Ronde, Connecticut; and Helen Fisher, Oregon.

After this hour of fun and nonsense came the serious high point of the meeting when the nurses of the New York City Department of Health presented a

life membership to Amelia Grant, their director. The presentation, which came as a complete surprise to Miss Grant, was made by Harriet Hohenfeld, supervising nurse in the Department.

By the end of the luncheon many visitors had drifted into the balcony above to share in the enjoyment, and it was with real regret that the meeting was adjourned until another Biennial Rally.

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Report of N.O.P.H.N. Sections

1938-1940

SINCE complete reports of the activities of the three Sections of the National Organization for Public Health Nursing for the biennial period 1938-1940 appeared in the *Biennial Report, 1938-1940*, sent by the National Organization for Public Health Nursing to its constituency, we are publishing only a brief resumé of the program and business meetings of these Sections at the Biennial Convention, together with the list of members of the Executive Committee of each Section for the coming biennial period.

INDUSTRIAL NURSING SECTION

THE PROGRAM for the Industrial Nursing Section of the N.O.P.H.N. at the 1940 Biennial Nursing Convention was both more intensive and more extensive than for previous meetings of the Section.

For the first time an intensive group conference or institute on industrial hygiene was arranged for the Saturday and Sunday preceding the Convention. The conference was conducted by Mr. J. J. Bloomfield, sanitary engineer with the U. S. Public Health Service, Washington, D. C., Dr. E. G. Meiter, director, Industrial Hygiene Laboratory, Employers Mutual Insurance Company, Milwaukee, Wisconsin, and Dr. Glenn S. Everts, industrial physician of Philadelphia, Pennsylvania. Joanna Johnson, chairman of the Section, led the informal discussions which followed presentation of various aspects of the subject. Between 60 and 70 nurses registered for this group conference.

The program of the Section was more extensive than ever before because of the increased number of sessions and the many public health nurses doing all types of work who attended.

Almost 200 lay people and nurses came to the luncheon meeting on May 13, which was arranged by the Phila-

delphia Industrial Nurses' Association. This meeting was addressed by Dr. Henry F. Vaughan, commissioner, Detroit Department of Health, who made a plea for the development of close relationships between the health units of industry and all the other health forces in the community, of which industrial health should be an integral part. The luncheon meeting was also in the nature of a birthday celebration for the New England Industrial Nurses' Association, which reached its twenty-fifth year in May. Catherine R. Dempsey, president of the Association and vice-chairman of the Industrial Nursing Section of the N.O.P.H.N., presided. The visitors were welcomed by Dr. Hubley R. Owen, director of the Philadelphia Department of Public Health, and Mrs. K. K. Dempsey, president of the Philadelphia Industrial Nurses' Association. Mrs. Anna M. Stabler, first president and organizer of the New England Industrial Nurses' Association, spoke briefly of early days in industrial nursing.

Two valuable papers on the general topic of tuberculosis in industry were presented to about 250 people on May 13. Dr. Maurice S. Jacobs, chairman of the Section on Public Health Preventative and Industrial Medicine, College of

Physicians, Philadelphia, spoke on "General Aspects of Tuberculosis in Industry." Dr. Charles-Francis Long, medical director of Bayuk Cigars, Inc., Philadelphia, discussed "Case-Finding in Industry." (See page 441.) Julia Weder, industrial nurse of the Giant Portland Cement Company, Egypt, Pennsylvania, reported on the program for tuberculosis control in her establishment.

More than 100 public health nurses doing all types of work came to what had been planned as a small and informal round table late Tuesday afternoon, May 14. At this session many questions were asked and many problems discussed concerning the work of nurses in industry.

The increased interest in industrial health shown both by the large attendance at industrial meetings and by the frequent mention of the health problems

of industry in other sessions of the Convention was most encouraging to Section members. Aided by this support from the whole body of public health nurses, they look forward to growth of the Section and to the development of industrial nursing as a public health service during the next two years.

Though no formal action was taken concerning the industrial program for the next Biennial Convention, the consensus expressed by individual nurses was that future meetings should be planned with shorter papers and more time allowed for informal discussion of problems of the industrial nurse.

A motion passed at the business meeting recommended to the N.O.P.H.N. Board of Directors that the Records Committee undertake a survey of industrial health records with a view to giving help to nurses working alone in small industries.

EXECUTIVE COMMITTEE FOR THE NEXT BIENNIAL PERIOD

Chairman—Joanna M. Johnson, R.N., Milwaukee, Wis.

Vice-Chairman—Catherine Dempsey, R.N., Cambridge, Mass.

Nurse Directors—Frances E. Bethune, R.N., Gastonia, N. C.; Marion Dowling, R.N., Ridgefield, N. J.; Mary Forbes, R.N., New York, N. Y.; Mrs. Blanche Lloyd Frances, R.N., Reading, Pa.; Mrs. Hazel H. Leedke, R.N., East Chicago, Ind.; Mrs. Bethel J. McGrath, R.N., Minneapolis, Minn.

Non-Nurse Directors—J. J. Bloomfield, Washington, D. C.; A. L. Brooks, M.D., Detroit, Mich.; W. H. Cameron, Chicago, Ill.; Joseph M. Conway, Green Bay, Wis.; Mrs. Austin T. Levy, Harrisville, R. I.

BOARD AND COMMITTEE MEMBERS' SECTION

WE SHALL probably never know just how many board and committee members have attended this convention, for while some have been here throughout the whole program, many came for only part, and it was particularly difficult to get the names of those from nearby places who perhaps attended only one or two sessions. And registering a lay person in this overwhelming group of nurses is quite a problem! The following figures, however, are correct as a minimum. There was lay representa-

tion from 22 states and Washington, D. C., and from 62 local communities.

In order to comply with suggestions made after the last convention, considerable time was allowed for discussion of common problems. Three round tables without formal programs were held. Although these were completely informal and any question might be brought up, much thought had been given to the topics to be covered and agency members were canvassed well in advance to find out what questions

were uppermost in the minds of our members.

The N.O.P.H.N. dinner sponsored by the Board and Committee Members' Section was attended by well over 700 persons. Mrs. David Remer and her local committee arranged to have hosts or hostesses from local agencies at the tables as far as possible, as well as having guests prominent in the field of health to sit at the head table. To say that Dr. C.-E. A. Winslow spoke on "Housing and Health" tells, in itself, that we had a fine and stimulating address. (See page 434.)

The lay group were invited to two delightful teas, one at the headquarters of The Visiting Nurse Society of Phila-

delphia where the president, Mrs. Cooper Howell, members of the board, Ruth W. Hubbard, general director, and members of her staff were most hospitable hosts. Mrs. William T. Dickson of the Ardmore Community Health and Civic Association entertained in her home in Overbrook where we enjoyed her lovely terrace and garden and met members of the board and staff of the Association.

At our round table on May 16 a short business meeting was held, and Mrs. Samuel W. Sawyer of Kansas City, Missouri, presented the slate for officers and members of the Executive Committee of this Section. These officers and members were unanimously elected:

EXECUTIVE COMMITTEE FOR THE NEXT BIENNIAL PERIOD

Chairman—Mrs. S. Emlen Stokes, Moorestown, N. J.

Vice-Chairman—Mrs. Langdon Thaxter, Portland, Me.

Lay Directors—Mrs. Louis L. Coudert, Hartford, Conn.; Mrs. Graham R. Hall, Little Rock, Ark.; Mrs. Herbert Hoover, Jr., Sierra Madre, Calif.; Mrs. Livingston Ireland, Cleveland, Ohio; Mrs. Joseph Lilienthal, New York, N. Y.; Mrs. Murray Rushmore, Plainfield, N. J.; Mrs. J. Randolph Tobias, Savannah, Ga.; Mrs. Roger Young, Newark, N. J.

Nurse Directors—Phyllis M. Dacey, Kansas City, Mo.; Pearl McIver, Washington, D. C.; Ann Nyquist, St. Paul, Minn.; Ruth Phillips, Denver, Colo.

SCHOOL NURSING SECTION

THIS CONVENTION has offered an increased program of special events for the School Nursing Section. As indicated by attendance and enthusiastic participation, the offerings were well chosen and pertinent to the needs and interests of the members.

The high point was the panel on "How can school and community join forces to serve the school child?" The chairman, Geraldine Hiller, and the eight panel members presented the type of discussion which is the ambition of every panel but attained by few. This was climaxed by a spirited participation on the part of the audience. Miss Hiller is a school nurse, Nurse-Teacher group, Public Schools, New Rochelle, New York.

The speaker at the luncheon was another real success. Dr. W. H. Blake of Teachers College, Columbia University, New York City, gave pointers and actual demonstrations for personality improvement in posture, speech, voice, and facing the world that were practical as well as exceedingly amusing.

Three round-table discussions were held: "Camp Nursing," led by Mrs. Kathryn O. Brownell, director, Y.W.C.A. School of Practical Nursing, Brooklyn, New York; "Supervision in School Nursing," led by Llouella L. Haage, supervisor of school nurses, Board of Education, Jersey City, New Jersey; and "College Nursing," led by Raidie Poole, college nurse and instructor of physiology and hygiene, State

Teachers College, Superior, Wisconsin.

There were two series of preconvention conferences, with a total attendance of 63, on "Nursing in Elementary Schools," with Marie Swanson, state supervisor of school nursing, New York State Education Department, as leader, and "Nursing in Secondary Schools," with Lula P. Dilworth, associate in health and safety education, New Jersey State Department of Public Instruction, as leader.

The business meeting of the Section was well attended in spite of its encroachment on the sightseeing period.

Certain needs of the nurse in the school were discussed during the preconvention conferences and other sessions. Because many of these items should receive emphasis during the next two-year period, they were included in the following resolutions passed by the Section for presentation to the National Organization for Public Health Nursing:

1. WHEREAS the N.O.P.H.N. in program arrangements provided generously for sessions of special interest to school nurses; BE IT RESOLVED that the Section express its appreciation to the N.O.P.H.N. for this thoughtful consideration.

2. WHEREAS Geraldine Hiller planned and conducted a pertinent and thought-provoking panel on the school and the community;

BE IT RESOLVED that the Section express to Miss Hiller its thanks and appreciation for this splendid contribution.

3. WHEREAS the Philadelphia school nurses through their supervisor, Edith Bishop, arranged the book exhibit which was requested for the preconvention conferences on school nursing;

BE IT RESOLVED that the Section express its appreciation for the services rendered.

4. WHEREAS the recently revised *Manual of Public Health Nursing* contains so excellent an interpretation of school nursing;

BE IT RESOLVED that the Section express to the N.O.P.H.N. its gratification at having available this helpful and challenging interpretation of school nursing.

5. WHEREAS there has been a wealth of material on subjects of peculiar interest to the

school nurse in each issue of *PUBLIC HEALTH NURSING* during the past two years;

BE IT RESOLVED that the Section express its appreciation to the editor of *PUBLIC HEALTH NURSING* for these educational contributions.

6. WHEREAS the members of the preconvention conferences expressed a desire for at least one more conference session at the next Biennial Convention if conferences are to be continued;

BE IT RESOLVED that the N.O.P.H.N. be requested to give due consideration to this request for additional time.

7. WHEREAS the members of the preconvention conferences believed that the convention program should receive more publicity;

BE IT RESOLVED that prior to the next Biennial Convention, announcements of conferences be sent to the commissioner of health and commissioner of education in each state asking their assistance in publicizing the Convention.

8. WHEREAS the lack of transfer of pupil health records from one district to another was presented as a general problem of conference members;

BE IT RESOLVED that the N.O.P.H.N. be requested to include in its promotional work the stimulation of interest of educational authorities in having health records routinely transferred when the pupil goes from any one school to another. (One such educational group to be approached is the American Association of School Administrators.)

9. WHEREAS there was a lack of understanding of the services rendered communities by the United States Public Health Service and by the United States Children's Bureau and the means to be employed in securing these services;

BE IT RESOLVED that the editor of *PUBLIC HEALTH NURSING* be requested to publish an article interpreting the policies which govern the rendering of services by the U. S. Public Health Service and the U. S. Children's Bureau.

10. WHEREAS one of the current needs in high-school health education is sex education and personal adjustments;

BE IT RESOLVED that the editor of *PUBLIC HEALTH NURSING* be requested to publish one or more articles on pre-parental education in the high school.

11. WHEREAS a need is becoming increasingly significant for the nurse to keep her academic and professional records up to date;

BE IT RESOLVED that the editor of *PUBLIC HEALTH NURSING* be requested to publish at least one article in the magazine advising the nurse on procedures to be employed in collecting and preserving academic and profes-

sional credentials and records of experience.

12. WHEREAS since our last meeting our ranks have been depleted by the death of Lulu V. Cline, one of the pioneer leaders in Section activities;

BE IT RESOLVED that the Section express its sorrow and profound regret over this loss and that this resolution be spread upon the minutes and a copy sent to the family of Miss Cline.

EXECUTIVE COMMITTEE FOR THE NEXT BIENNIAL PERIOD

Chairman—Mellie Palmer, R.N., Minneapolis, Minn.

Vice-Chairman—Ella E. McNeil, R.N., Ann Arbor, Mich.

New Nurse Directors—Fern Goulding, R.N., Ames, Iowa; Grace Lawrence, R.N., Newton, Mass.

New Non-Nurse Director—Ellen C. Potter, M.D., Trenton, N. J.

Nurse Directors holding over from last biennial period—Gertrude Cromwell, R.N., Des Moines, Iowa; Kathleen Leahy, R.N., Seattle, Wash.

Non-Nurse Director holding over from last biennial period—Dean Franklin Smiley, M.D., Ithaca, N. Y.

SEEING YOURSELF AS OTHERS SEE YOU

THOSE OF YOU who were not fortunate enough to attend the luncheon of the School Nursing Section on May 15 in Philadelphia will probably be dyed a deep green shade of envy because you missed an opportunity to learn how to present yourself as you would like to have others see you.

Two hundred nurses attended this meeting, at which Marie E. Swanson, chairman of the Section, and supervisor of school nursing in the New York State Education Department, presided. The speakers' table was gay with flowers.

The feature of the luncheon was the address of the guest speaker, Dr. W. H. Blake of Teachers College, Columbia University, who gave some illuminating demonstrations and pointers on how to behave if we would have others see us as we want to be seen. It is of course impossible to reproduce his pantomime in words but salient points of the demonstrations are summarized here:

According to Dr. Blake we should:

1. Consider the impression we want to make and then use the methods that will produce that impression.

2. Know what we are expressing. We are judged by posture, clothes, voice, and vocabulary. Apropos of the importance of posture it is well to realize that curves in the figure always express

emotion. Presenting the shoulder first produces an impression of antagonism. The curve and the bend combined portray subtlety of emotion. Standing feet together denotes subservience. The elbow is the thermometer of self-esteem. The inward-turned agents denote weakness and the outward-turned agents indicate strength. An absence of curves results in an appearance of simplicity and straightforwardness; but curves—whether of the head, face, shoulder, torso, finger, elbow, hips, or feet—portray type and degree of emotion.

3. After considering what emotion we want to express we should proceed to share it with the other person or the group—portraying, by our physical interpretation, the mental attitude of wanting to share it.

To summarize, if the James-Lange theory of emotions is true, we do not run because we are afraid, but we are afraid because we run. Dr. Walter Cannon after rather thorough experiments also finds the major premise of this theory to be correct. Therefore, we need to consider carefully what emotion we *are* or *are not* expressing by our posture and mental attitude because people interpret not words only, but words as supported by physical expression. A. G.

The September issue will be a special school and preschool number

Information Please

By LOUISE HOPWOOD

Part III

Data on charges for full-pay visits, hourly appointment service, delivery service, bedside care in official agencies, and certain aspects of school nursing are presented here

A FULL-PAY VISIT may be defined as a visit made to a patient, in which the full charge for the visit as set by the organization is paid by the patient or other interested person. Of the 225 nonofficial agencies in the sample, 8 agencies reported that they made no charges for their nursing services and 9 agencies stated that they made a charge but did not give the amount. That left a total of 208 agencies giving usable information.

The most usual charge was \$1 to \$1.09. Sixty-eight percent of the agencies reported amounts within this range. Forty agencies reported \$1.10 or more, and of these 14 charged \$1.50 and over. In 24 agencies the charge was less than 90 cents; 22 of these agencies employed less than 10 nurses and 11 of the 22 were one-nurse organizations.

Several agencies reported they charged more for a postpartum visit, but the charge was only slightly higher than the usual full-pay charge for a single patient. Several agencies charged more for special services such as irrigations and hyperdermics.

HOURLY APPOINTMENT SERVICE

An hourly appointment service is a service in which the agency agrees to give care at a specified time. There were 132 agencies which stated they did not maintain an hourly appointment service.

Seven agencies did not answer this question, while four did not give their charge. Of the remaining 82 agencies, 45 organizations reported a charge of \$1.50 to \$1.99 for the first hour of care; 12 charged \$2 or more; 13 charged from \$1.25 to \$1.49; 11 charged from \$1 to \$1.10; one agency charged less than \$1. The charge for additional time was stated in so many ways that the figures were not comparable but the range was from 25 cents to \$2 for each additional hour of care.

The question was also asked concerning the maximum length of visit allowable on an hourly appointment case. The most usual maximum time was from 2 to 4 hours. Twenty-four agencies reported 2 to 3 hours, and 25 agencies reported 3-to-4-hour visits. Thirteen agencies stated that there was no time limit.

When this information is considered in relationship to the size of the agency, it is found that small agencies are less likely to have an hourly appointment service than the larger agencies. Of the agencies employing 10 or more nurses, 56 percent had this service, while only 28 percent of the agencies employing less than 10 nurses maintained an hourly appointment service. The size of the agency does not, however, noticeably affect the charge for the first hour or the maximum length of visit.

DELIVERY SERVICE

The nonofficial agencies were asked whether they maintained a delivery service, and if so, what charge was made for the service and what was the number of

deliveries in 1938. Of the 225 replying, 96 agencies stated they had a delivery service. Of these, 59 agencies stated they made a flat charge of \$5 per delivery; 10 stated their initial charge was \$5, and that over a specified number of hours an additional charge was made. There were 2 agencies which said no charge was made, and 4 agencies did not answer the question. The remaining 21 agencies charged from \$2 up to \$10 a delivery. It is the custom in agencies making a small charge, however, to set a time limit and then to charge an additional fee on the per hour basis for time exceeding that limit.

Of the 90 agencies giving information regarding the number of deliveries during the year 1938, 68 reported less than 100 deliveries, and 33 less than 25 deliveries in the year. One agency, however, reported 1813 deliveries. The 90 agencies reported that they assisted in delivery care for 11,091 women.

BEDSIDE CARE

A total of 69 health departments of the 194 reporting stated that they gave bedside care for other than demonstration purposes. There were, however, 26 limitations on the type of cases to which care was given in 22 agencies. Nine agencies stated they gave care only to indigent or relief patients and eleven agencies gave care only to communicable disease patients. The other 6 agencies limited their care to tuberculosis patients, maternity patients, or children.

The health departments were also asked concerning the amount charged for bedside care. Only ten agencies reported that a fee was charged for this service. It is interesting that 4 of these 10 agencies were at one time considered "combination agencies." They have now become health departments but retain some of the characteristics of nonofficial agencies. Five agencies were the only

organizations in their communities. One agency had been used at one time as an experimental area. There was no limitation placed on the type of cases taken for care, but one of the former combination agencies charged only for delivery service. The amount of the charge was not given.

RATIO OF CHILDREN TO NURSES

The boards of education were asked the number of school children served during 1938. In order to compare the amount of school nursing service among the 109 boards of education, the ratio of children to nurses was calculated for each nursing service. In the median school the ratio was 2239 children per school nurse. The size of the community seemed to affect this ratio. There were too few metropolitan and rural communities in this sample to permit generalization. However, communities from 50,000 to 99,999 population had the highest ratio, which was 2813 pupils per school nurse. The ratio decreased as the ends of the range in population were approached. For communities of 150,000 to 499,999, the number of children per nurse was 1688; and for incorporated communities of 2500 to 9999, the number per nurse was 1625.

PAROCHIAL SCHOOL NURSING

The agency providing the school nursing service for parochial schools was most often the health department in 1938 as shown by the replies from boards of education. The 82 agencies giving usable data showed that in 50 communities the health department furnished this service, and in 21 places, the board of education. Three places used nonofficial agencies and 3 places used other nurses. The remaining 5 places did not have regular inspection but received immunizations and care during epidemics.

(Continued)

NOTES *from the* NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

VIRGINIA A. JONES

It is with regret unmingled with reconciled feelings of any description that we announce the resignation of Virginia A. Jones as assistant director of the N.O.P.H.N. staff in charge of educational problems. Miss Jones is going to the University of Hawaii in September. We wish her every success, every happiness, every professional and personal satisfaction, and naturally congratulate Hawaii. It is hard to find a ray of comfort in the thought that the N.O.P.H.N. has produced another director of a program of study in public health nursing—the third in five years. We know there will be hundreds of nurses all over the United States who will sigh when they see this announcement and will say, "I wish she could have stayed on our national staff." No one wishes it more than the N.O.P.H.N. Board, committees, and staff. We feel as though a part of the N.O.P.H.N. would be in Hawaii this fall. We repeat, congratulations Hawaii and *aloha* Miss Jones.

WITH THE STAFF

Since some of the staff went on vacation in June and there was very little activity in the field, only a few short trips were made by the staff members.

Dorothy Deming went to Poughkeepsie, N. Y., on June 11 to meet with the district nurses of the State Department of Health. While there, she also met with the Brewster and Cold Spring-Garrison committees.

Purcell Peck attended the annual meeting of the National Tuberculosis Association in Cleveland, Ohio, the week of June 3.

On June 17, Evelyn Davis met with the steering committee of the lay sec-

tion of the New Jersey S.O.P.H.N. in Trenton.

The institute for administrators, teachers, and supervisors in nursing at the University of Chicago was attended by Virginia Jones from June 20 to 22. She participated in the session for administrators and supervisors in public health nursing.

HONOR ROLL

We're heading for the biggest Honor Roll year ever achieved by the N.O.P.H.N.! Over 440 agencies have been added to the list this month—bringing the total number of 100 percent services to over 900. Without a doubt this list would be even longer if all the agencies would notify us of their eligibility.

As soon as your staff is 100 percent enrolled in the N.O.P.H.N. let us know so that the name of your service (one-nurse services are included) may be added to this imposing list of 1940 Honor Roll Agencies.

We want to make 1940 the best Honor Roll year ever and with your help we can do it!

ALABAMA

- *Shelby County Health Department, Columbiana
- *Tallapoosa County Health Department, Dadeville
- Lauderdale County Health Department, Florence
- Geneva County Health Department, Geneva
- Hale County Health Department, Greensboro
- Butler County Health Department, Greenville
- Marshall County Health Department, Guntersville
- *Perry County Health Unit, Marion
- *Bureau of Hygiene and Nursing, Montgomery
- Autauga County Health Department, Prattville

Talladega County Health Department,
Talladega

*Pike County Health Unit, Troy

ARIZONA

Chandler Public School Nursing Service,
Chandler

*Pima County Health Unit, Tucson

Yuma County Public Health Unit, Yuma

ARKANSAS

*Independence County Health Unit,
Batesville

*Fort Smith Public Schools, Fort Smith
Metropolitan Life Insurance Nursing
Service, Fort Smith

Ashley County Health Unit, Hamburg
Poinsett County Health Unit, Harrisburg
Metropolitan Life Insurance Nursing
Service, Jonesboro

Visiting Nurse Association of Greater
Little Rock, Little Rock

Columbia County Health Unit, Magnolia
Greene County Health Nursing Service,
Paragould

State Board of Health, Fulton County
Health Unit, Salem

*Scott County Health Department, Wal-
dron

CALIFORNIA

Metropolitan Life Insurance Nursing
Service, Bakersfield

Department of Health in Mono and
Alpine Counties, Bridgeport

*Coalinga School Nursing Service, Coal-
inga

Imperial County Health Department,
El Centro

Metropolitan Life Insurance Nursing
Service, Fresno

Curriculum in Public Health Nursing,
University of California, Los Angeles

John Hancock Visiting Nurse Service,
Los Angeles

Metropolitan Life Insurance Nursing
Service, Los Angeles

Madera County Health Unit, Madera

Metropolitan Life Insurance Nursing
Service, San Leandro, Oakland

Metropolitan Life Insurance Nursing
Service, Palo Alto

*Pittsburg Public Schools, Pittsburg
Junior Aid Visiting Nurse, Riverside

Metropolitan Life Insurance Nursing
Service, Riverside

*Metropolitan Life Insurance Nursing
Service, San Diego

*Visiting Nurses of San Diego, San Diego
Metropolitan Life Insurance Nursing
Service, San Jose

San Jose Chapter, American Red Cross
Visiting Nurse Service, San Jose

*Santa Barbara Visiting Nurse Associa-
tion, Santa Barbara

Santa Maria Union Valley High School,
Santa Maria

*Agencies which have been on the Honor Roll
for five years or more.

San Joaquin Local Health District,
Stockton

COLORADO

Boulder County Nursing Service, Boulder
Visiting Nurse Association, Colorado
Springs

Montezuma County Public Health Nurs-
ing Service, Cortez

Delta County Nursing Service, Delta
La Plata County Public Health Nursing
Service, Durango

Morgan County Public Health Nursing
Service, Ft. Morgan

Colorado State College of Education,
Greeley

Grand County Public Health Service,
Hot Sulphur Springs

Bent County Public Health Nursing
Service, Las Animas

Metropolitan Life Insurance Nursing
Service, Pueblo

Pueblo City Health Department, Pueblo
Pueblo School District No. 1, Pueblo

Pueblo School District No. 20, Pueblo
Logan County Public Health Nursing
Service, Sterling

CONNECTICUT

Bridgeport Branch of the Connecticut
State Child Welfare Bureau, Bridgeport

*District Nurse Association of Ansonia,
Derby, and Shelton, Derby

Public Health and Visiting Nurse Asso-
ciation, Meriden

*District Nursing Association, Middletown
Visiting Nurse Association of New
Britain, New Britain

School Nurses, Board of Education,
Stamford

Stonington Visiting Nurse Association,
Stonington

*Metropolitan Life Insurance Nursing
Service, South Norwalk

Public Health Nursing Association of
Trumbull, Trumbull

*Community Nursing Service of the Wal-
lingford Tuberculosis and Relief Asso-
ciation, Wallingford

Windsor Public Health Nurse Associa-
tion, Windsor

FLORIDA

Hernando County Public Health Nursing
Service, Brooksville

Broward County Health Department,
Hollywood

Metropolitan Life Insurance Nursing
Service, Jacksonville

State Board of Health—District No. 2,
Jacksonville

Hendry County Health Department,
La Belle

Miami Public Health Nursing Service,
Miami

Metropolitan Life Insurance Nursing
Service, Orlando

Bay County Health Unit, Panama City

Gulf County Public Health Nursing Service, Port St. Joe
 Indian River County Public Health Nursing Service, Vero Beach
 Hardee County Health Department, Wauchula

GEORGIA

Union Bag and Paper Corporation, Savannah
 Metropolitan Life Insurance Nursing Service, West Point

IDAHO

Metropolitan Life Insurance Nursing Service, Boise
 Fort Hall Nursing Service, Fort Hall
 *Bunker Hill and Sullivan Mining and Concentrating Company, Kellogg
 Metropolitan Life Insurance Nursing Service, Pocatello

ILLINOIS

*Belleville Public Schools, Belleville
 *Metropolitan Life Insurance Nursing Service, Belleville
 City Health Department, Bloomington
 Metropolitan Life Insurance Nursing Service, Bloomington
 Henry County Tuberculosis Sanitarium Board, Cambridge
 Fulton County Public Health Program, Canton
 Metropolitan Life Insurance Nursing Service, Carbondale
 Carlinville Red Cross, Carlinville
 Goodman Manufacturing Company, Chicago
 *Chicago Tuberculosis Institute, Chicago
 Decatur School Health Department, Decatur
 Tuberculosis Sanatorium Board of Lee County, Dixon
 *Evanston Infant Welfare Society, Evanston
 *Amity Child Welfare Society, Freeport
 Freeport City Health Department Nursing Service, Freeport
 Stephenson County School Nursing Service, Freeport
 *Stephenson County Tuberculosis Board, Freeport
 Monticello College Nursing Service, Godfrey
 John Hancock Visiting Nurse Service, Granite City
 Mason County Public Health Nursing and Tuberculosis Association, Havana
 Board of Education, Hinsdale
 City Health Department Nursing Service, Jacksonville
 Morgan County Health Department, Jacksonville
 Western Illinois State Teachers College, Macomb
 Marseilles Nursing Service, Marseilles
 Clark County Public Health Nursing Service, Marshall

Board of Education, District 89, Maywood
 Mendota Public Schools, Mendota
 *Moline Public Health Nursing Service, Moline
 Wabash County Nursing Service, Mt. Carmel
 *Metropolitan Life Insurance Nursing Service, Oak Park
 Pekin Community High School, Pekin
 *Peoria Visiting Nurse Association, Peoria
 Pike County Public Health Nursing Association, Pittsfield
 Livingston County Public Health Nursing Association, Pontiac
 *Visiting Nurse Association, Rockford
 Visiting Nurse Association, Rock Island
 *Whiteside County Sanitarium Board, Sterling
 Cumberland County School Health Association, Toledo
 Iroquois County Public Health Nursing Service, Watseka

INDIANA

Steuben County Health Department, Angola
 Perry County Public Health Nursing Service, Cannelton
 Tuberculosis Association of Allen County, Fort Wayne
 *Visiting Nurse League, Fort Wayne
 *John Hancock Mutual Life Insurance Nursing Service, Gary
 Lake County Tuberculosis Association, Gary
 Metropolitan Life Insurance Nursing Service, Gary
 *Elkhart County Tuberculosis Association, Goshen
 LaPorte County Public Health Nursing Service, LaPorte
 *Ball State Teachers College Nursing Service, Muncie
 *New Castle Public Health Nursing Association, New Castle
 Vermillion, Eugene, and Highland Townships Nursing Service, Newport
 *Jackson County Public Health Nursing Service, Seymour
 *Hygiene Department, Terre Haute City Schools, Terre Haute
 *Valparaiso Board of Education, Valparaiso

IOWA

10th Iowa District Public Health Nurses, Algona
 Hygiene Department, Iowa State College, Ames
 Boone County Nursing Service, Boone
 Cedar Falls Public Schools, Cedar Falls
 Health District No. 2—Iowa State Department of Health, Centerville
 Charles City Board of Education, Charles City
 Cherokee Board of Education, Cherokee
 Independent School District of Clinton, Clinton

*Visiting Nurse Association, Davenport
 *State Department of Health, Des Moines
 Dubuque County Public Health Nursing Service, Dubuque
 District Health Service No. 4, Fort Dodge
 Harlan School Nursing Service, Harlan
 Indianaola Board of Education, Indianaola
 Public Health Nursing Department of Orthopedic Mobile Clinic Service, Iowa City
 State University of Iowa Nursing Service, Iowa City
 Keokuk Public Schools, Keokuk
 Metropolitan Life Insurance Nursing Service, Keokuk
 Marion County Nursing Service, Knoxville
 Marshalltown Independent School District, Marshalltown
 Cerro Gordo County Red Cross Nursing Service, Mason City
 Mason City School Nursing Service, Mason City
 Mahaska County Nursing Service, Oskaloosa
 Oskaloosa Public Schools, Oskaloosa
 Red Cross School Nursing Service, Perry
 O'Brien County Nursing Service, Primghar
 Calhoun County Nursing Service, Rockwell City
 Sac County Nursing Service, Sac City
 Osceola County Public Health Nursing Service, Sibley
 *Sioux City Public Schools, Sioux City
 *Visiting Nurse Association, Sioux City
 Black Hawk County Nursing Service, Waterloo
 Winterset Public Schools, Winterset

KANSAS

Public Health Nursing Association, Coffeyville
 *Emporia Board of Education, Emporia
 Allen County Visiting Nurse Service, Iola
 Board of Education, Kansas City
 Wyandotte County American Red Cross Chapter, Kansas City
 Lawrence City School Nursing Service, Lawrence
 *McPherson County Chapter, American Red Cross, McPherson
 Newton Public Health Nursing Association, Newton
 Salina Board of Education, Salina
 Haskell County Public Health Nursing Service, Sublette
 *Coleman Lamp and Stove Company, Wichita
 Wichita Tuberculosis Association, Wichita
 *Winfield Board of Education, Winfield

KENTUCKY

Anderson County Health Department, Lawrenceburg

*Agencies which have been on the Honor Roll for five years or more.

Scott County Health Department, Georgetown
 John Hancock Mutual Life Insurance Company Nursing Service, Kenton and Campbell Counties
 Wayne County Health Department, Monticello
 Metropolitan Life Insurance Nursing Service, Owensboro
 Morgan County Health Department, West Liberty

LOUISIANA

Catahoula Parish Health Unit, Harrisonburg
 Ouachita Parish Chapter, American Red Cross, Monroe
 *Child Welfare and Community Health Association, New Orleans
 Allen Parish Health Unit, Oberlin

MAINE

*Augusta Red Cross Nursing Service, Augusta
 *Central Penobscot Public Health Association, Old Town
 *Lewiston-Auburn Chapter, American Red Cross, Lewiston

MARYLAND

Dorchester County Tuberculosis Association, Inc., Cambridge

MASSACHUSETTS

Division of Child Hygiene of the Massachusetts Department of Public Health, Boston
 John Hancock Mutual Life Insurance Visiting Nurse Service, Boston
 *Dalton Visiting Nurse Association, Dalton
 *Dedham Emergency Nursing Association, Dedham
 John Hancock Mutual Life Insurance Nursing Service, Everett
 Metropolitan Life Insurance Nursing Service, Haverhill
 District Nursing Department, Lawrence General Hospital, Lawrence
 *Metropolitan Life Insurance Nursing Service, Malden
 *Instructive Nursing Association, New Bedford
 Newton District Nursing Association, Newtonville
 John Hancock Visiting Nurse Service, North Adams
 *Worcester Society for District Nursing, Worcester

MICHIGAN

*Public Health Nursing Service of the Civic League and City of Bay City, Bay City
 *Berkley Board of Education, Berkley
 *Visiting Nurse Association, Detroit
 District Health Department No. 7, Gladwin
 Dickinson County Health Department No. 12, Iron Mountain

District Health Department No. 1, Lake City
 Ingham County Health Department, Mason
 *Midland County Department of Health, Midland
 Central State Teachers College, Mount Pleasant
 District Health Department No. 6, Newberry
 Baraga-Ontonagon District Health Department No. 19, Ontonagon
 Chippewa County Health Department, Sault Ste. Marie
 Sanilac County Health Department No. 17, Sandusky
 Iron County Health Department No. 11, Stambaugh
 District Health Department No. 4, Rogers City
 District Health Department No. 2, West Branch
 District Health Unit No. 5, White Cloud

MINNESOTA

Carlton County Nursing Service, Carlton
 Metropolitan Life Insurance Nursing Service, Duluth
 St. Louis County Health Department, Duluth
 McLeod County Public Health Association, Glencoe
 District Office, Minnesota Department of Health, Mankato
 *Division of Child Hygiene, Minnesota Department of Health, Minneapolis
 Bureau for Crippled Children, Division of Social Welfare, St. Paul
 Ramsey County Nursing Service, St. Paul
 White Bear Public Schools Nursing Service, White Bear Lake

MISSISSIPPI

Lincoln County Health Department, Brookhaven
 Marshall County Health Department, Holly Springs
 Metropolitan Life Insurance Nursing Service, Laurel
 Choctaw Indian Agency, Philadelphia

MISSOURI

Metropolitan Life Insurance Nursing Service, Cape Girardeau
 Jefferson City Public Schools, Jefferson City
 Metropolitan Life Insurance Nursing Service, Jefferson City
 Ray County Public Health Nursing Service, Richmond
 *Atchison County Public Health Nursing Association, Rock Port
 John Hancock Mutual Life Insurance Nursing Service, St. Louis County
 Metropolitan Life Insurance Nursing Service, Sedalia
 Jasper County Health Department, Webb City

MONTANA

Metropolitan Life Insurance Nursing Service, Billings
 *Metropolitan Life Insurance Nursing Service, Butte
 *Dillon Public Schools Nursing Service, Dillon
 Fort Peck Maternity Demonstration Center, Fort Peck
 Metropolitan Life Insurance Nursing Service, Great Falls
 Metropolitan Life Insurance Nursing Service, Missoula
 Missoula City-County Health Unit, Missoula
 Jefferson County Nursing Service, Whitehall

NEW HAMPSHIRE

Bradford School Nursing District, Bradford
 *Ossipee Chapter American Red Cross, Center Ossipee
 Laconia Nursing Service, Laconia
 *Milton Branch, American Red Cross, Milton
 *Pittsfield Public Health Nursing Association, Pittsfield
 Portsmouth Board of Education, Portsmouth

NEW JERSEY

Metropolitan Life Insurance Nursing Service, Burlington
 *Cape May Branch, American Red Cross, Cape May
 *Matawan Public Health Association, Matawan
 *Merchantville-Pennsauken Visiting Nurse Association, Merchantville
 Visiting Nurse Association of Newark, Newark
 *Visiting Nurse Association of Plainfield and North Plainfield, Plainfield
 Somerset County Tuberculosis and Health Association, Somerville
 Ocean County Tuberculosis and Health Association, Toms River
 *District Nursing Association, Westfield

NEW MEXICO

Eddy County Nursing Service, Carlsbad
 Lincoln County Health Department, Carrizozo
 Union County Department of Public Health, Clayton
 *Torrance County Health Department, Estancia
 Hobbs Public Schools Nursing Service, Hobbs
 Dona Ana County Health Department, Las Cruces
 Harding County Health Department, Mosquero
 Roosevelt County Health Department, Portales
 Colfax County Health Department, Raton
 *State Department of Public Health, Santa Fe

NEW YORK

- *Metropolitan Life Insurance Nursing Service, Auburn
- Metropolitan Life Insurance Nursing Service, Binghamton
- *Visiting Nursing Association of Buffalo, Buffalo
- *East Aurora Branch, American Red Cross, East Aurora
- District Nursing Association, Carmel
- *American Red Cross Visiting Nurse Service, Geneva
- District State Health Office, Geneva
- Gowanda Red Cross Nursing Service, Gowanda
- *Hartsdale Union Free School Nursing Service, Hartsdale
- John Hancock Mutual Life Insurance Nursing Service, Hempstead
- Metropolitan Life Insurance Nursing Service, Ilion
- Hamilton County Nursing Service, Indian Lake
- Wayne County Public Health Service, Lyons
- Metropolitan Life Insurance Nursing Service, Mechanixville
- Orleans County Public Health Service, Medina
- The Nassau and Suffolk Counties Committee on Mother's Health Centers, Mineola
- *Metropolitan Life Insurance Home Office Administrative Nursing Staff, New York
- Cattaraugus County Department of Health, Olean
- John Hancock Mutual Life Insurance Nursing Service, Patchogue
- Public Health Association of Putnam Valley and Kent District No. 1, Peekskill
- Metropolitan Life Insurance Nursing Service, Tonawanda
- *Public Health Nursing Organization of Eastchester, Inc., Tuckahoe
- Metropolitan Life Insurance Nursing Service, Watertown

NORTH CAROLINA

- Orange-Person-Chatham District Health Department, Chapel Hill
- Davidson County Health Department, Lexington
- Anson County Health Department, Wadesboro
- Wilkes County Health Department, Wilkesboro

NORTH DAKOTA

- City Nursing Service of Bismarck, Bismarck
- *Fargo Health Department, Fargo
- Walsh County Public Health Nursing Service, Grafton
- Ransom County Public Health Nursing Service, Lisbon
- Eddy County Health Department, New Rockford

- Barnes County Public Health Nursing Service, Valley City
- City and School Public Health Nursing Service, Valley City
- Richland County Health Department, Wahpeton

OHIO

- *Metropolitan Life Insurance Nursing Service, Cincinnati
- Cleveland Visiting Nurse Association, Branch No. 3, Cleveland
- Division of Public Health Nursing, State Department of Health, Columbus
- The Middletown Civic Association, Middletown
- Metropolitan Life Insurance Nursing Service, Piqua
- Visiting Nurse Association, Ravenna
- Metropolitan Life Insurance Nursing Service, Sandusky
- Metropolitan Life Insurance Nursing Service, Zanesville

OKLAHOMA

- Panhandle Tri-County Health Unit, Guymon
- Five Civilized Tribes, Muskogee
- LeFlore County Health Unit, Poteau
- *Metropolitan Life Insurance Nursing Service, Tulsa

OREGON

- Linn County Health Service, Albany
- Coos County Health Unit, Coquille
- Polk County Health Association, Dallas
- Josephine County Health Unit, Grants Pass
- Hood River County Health Association, Hood River
- Union County Health Unit, La Grande
- Yamhill County Health Unit, McMinnville
- Jackson County Health Department, Medford
- Malheur County Public Health Association, Ontario
- *Clackamas County Health Department, Oregon City
- Crippled Children's Division, State Public Welfare Commission of Oregon, Portland
- Department of Nursing Education, University of Oregon Medical School, Portland
- Douglas County Public Health Unit, Roseburg
- Metropolitan Life Insurance Nursing Service, Salem
- *Wasco County Health Unit, The Dalles
- Tillamook County Health Service, Tillamook

PENNSYLVANIA

- Metropolitan Life Insurance Nursing Service, Allentown
- Metropolitan Life Insurance Nursing Service, Beaver Falls

*Agencies which have been on the Honor Roll for five years or more.

- *Giant Portland Cement Company, Egypt
- Lansdale Community Service, Lansdale
- Pottstown Public Schools, Pottstown
- *Chester Valley Red Cross Community Nurse Association, Whitford

RHODE ISLAND

- *Bristol District Nursing Association, Bristol
- *Bristol Public Schools, Bristol
- Town of Lincoln School Nursing Service, Lincoln
- *Providence District Nursing Association, Providence
- North Kingstown Visiting Nurse and Anti-Tuberculosis Association, Wickford

SOUTH CAROLINA

- Beaufort County Nursing Service, Bluffton
- Edgefield County Health Department, Edgefield
- Florence County Health Department, Florence
- *Metropolitan Life Insurance Nursing Service, Greenville
- Calhoun County Health Department, St. Matthews

SOUTH DAKOTA

- *Aberdeen Public Schools, Aberdeen
- Harding County Public Health Unit, Buffalo
- Hutchinson County Public Health Unit, Freeman
- First District Public Health Unit, Philip
- Board of Education of Rapid City, Rapid City
- Pennington County Public Health Unit, Rapid City
- Sioux Falls Board of Education, Sioux Falls
- City Health Department, Sioux Falls
- Board of Education, Yankton

TENNESSEE

- Metropolitan Life Insurance Nursing Service, Bristol
- *Metropolitan Life Insurance Nursing Service, Chattanooga
- *Lincoln County Health Department, Fayetteville
- *Metropolitan Life Insurance Nursing Service, Knoxville
- *Davidson County Health Department, Nashville
- *Department of Nursing Education, George Peabody College for Teachers, Nashville

TEXAS

- Taylor County Red Cross Chapter, Abilene
- Brazoria County Public Health Nursing Service, Angleton
- Texas Tuberculosis Association, Austin
- Travis County Health Department, Austin

Runnels County Health Association, Ballinger

- *Bryan-Brozaz County Health Unit, Bryan

Public Health District Number Four, State Health Department, Bryan

Van Zandt County Health Department, Canton

Val Verde Nursing Service, Del Rio

El Paso City-County Health Unit, El Paso

Tarrant County Health Unit, Fort Worth

- *Galveston Public Health Nursing Service, Galveston

*Anti-Tuberculosis League, Houston

Lefors Independent Schools Nursing Service, Lefors

Polk County Health Department, Livingston

Midland City-County Health Unit, Midland

San Angelo School Nursing Service, San Angelo

Hudspeth County Nursing Service, Sierra Blanca

Tyler Public Schools Nursing Service, Tyler

Uvalde-Zavala County Health Unit, Uvalde

Willbarger County Health Department, Vernon

Wichita Falls City Health Department, Wichita Falls

UTAH

Metropolitan Life Insurance Nursing Service, Ogden

- *Utah Tuberculosis Association, Salt Lake City

VIRGINIA

Instructive Visiting Nurse Association of Arlington, Arlington

- *Charlotte County Chapter, American Red Cross, Charlotte

Metropolitan Life Insurance Nursing Service, Lynchburg

Fauquier County Red Cross Public Health Nursing Service, Warrenton

WASHINGTON

Lincoln County Health Department, Davenport

Metropolitan Life Insurance Nursing Service, Everett

- *Public Health Nursing Association, Tacoma

Clark County-City Health Department, Vancouver

WEST VIRGINIA

- *Huntington Tuberculosis Association, Huntington

WISCONSIN

Department of School Hygiene, Appleton City Schools, Appleton

Employers Mutual Liability Insurance Company, Appleton

Chippewa County Health Department,
Chippewa Falls

Walworth County Public Health Nursing
Service, Elkhorn

*City Health Department, La Crosse
Metropolitan Life Insurance Nursing

Service, Madison

Metropolitan Life Insurance Nursing
Service, Marinette

Out-Patient Department, St. Joseph's
Hospital Annex, Milwaukee

*Wisconsin Anti-Tuberculosis Association,
Milwaukee

Metropolitan Life Insurance Nursing
Service, Racine

Metropolitan Life Insurance Nursing
Service, Superior

Two Rivers Health Department, Two
Rivers

Board of Education, Waukesha

WYOMING

Star Valley District, Afton

Natrona County High School, Casper

ALASKA

Anchorage Department of Health, An-
chorage

Fairbanks Department of Health, Fair-
banks

Alaska Territorial Department of Health,
Juneau

Juneau Public Health Nursing Service,
Juneau

Ketchikan Department of Health, Ketch-
ikan

Nome Department of Health, Nome

Palmer Department of Health, Palmer

Petersburg Department of Health,
Petersburg

Seldovia Department of Health, Seldovia

Seward Department of Health, Seward

Sitka Department of Health, Sitka

Wrangell Department of Health, Wran-
gell

American Red Cross Appointments

MISS F. Elizabeth Crowell has accepted an appointment as advisor on nursing and other related fields on the staff of the American Red Cross delegation, with headquarters in Paris.

It seldom happens that when a great human need becomes apparent, the exact individual capable of fitting into that situation is ready. But it is true that Miss Crowell's experience will enable her to make use of every available French nurse whose education and experience will make her useful in the efforts of the Red Cross to relieve the terrible suffering of the refugees in France.

Miss Crowell was associated with Dr. Livingston Farrand, Dr. Linsly Williams, and other distinguished leaders in relief work in France twenty years ago. Since that time, as a member of the European staff of the Rockefeller Foundation, she has spent all her time in cooperating with France and other European countries in the development

of modern schools of nursing. It is hardly too much to say that she knows all the doctors and nurses in France who are engaged in the public health program of that country or are connected with the medical and nursing schools of France.

An honorary member of the International Council of Nurses, Miss Crowell is intimately acquainted with the work of the Red Cross in many countries, and the American Red Cross will now have her knowledge and experience at its disposal in the work for refugees in France.

Helen F. Dunn, assistant director of the Nursing Service in charge of public health nursing of the American Red Cross, resigned on June 15 to accept a position in the Maine State Department of Health and Welfare.

After distinguished service abroad with the Harvard Surgical Unit (1916-1919) Miss Dunn was assigned to duty in 1925 in the Virgin Islands, and has been connected with the Red Cross al-

most continuously since then. She has served the organization through a difficult period in its history—a period which saw its readjustment after the close of the first World War, and the growth and expansion of the various Red Cross services—in assignments of ever-increasing responsibility, culminating in her appointment to her present position in 1939. Her background and experience were invaluable in the reorganization and unification of the Nursing Service.

For some time it has been Miss Dunn's ambition to secure the particular type of experience available only in a state department of health, and while it is with the deepest regret that we are losing her just now, nevertheless we sympathize with and fully understand her desire in this connection. Our very best wishes for success in her new position, together with our appreciation for the fine service she has rendered, go with her.

To take Miss Dunn's place, we consider that the Red Cross is unusually fortunate in securing Mrs. Elsbeth H. Vaughan, who is coming to us from her present position as executive secretary of the Detroit Council on Community Nursing. Mrs. Vaughan is well known

to nurses throughout the country, having served the Red Cross for a number of years in important positions. She first came to the organization early in 1917 as assistant to the director of nursing service, in which capacity she helped with the assignment of nurses to military service. After a period as assistant director of public health nursing in the Michigan State Department of Health, she returned to the Red Cross in 1921 as assistant director of Nursing Service of the American Red Cross Commission to Europe. Following this experience she again accepted a position with the Michigan State Department of Health, remaining there until 1924, when she became assistant director of nursing of the Red Cross, first with the Branch Office in Chicago, and then with the Midwest Branch Office in St. Louis.

In 1935 Mrs. Vaughan was awarded the Florence Nightingale Medal, the highest Red Cross decoration that can be bestowed upon a nurse.

It is at considerable sacrifice of her personal plans that Mrs. Vaughan is again returning to the Red Cross, thereby making available to us in the critical times that lie ahead her unusual and valuable experience.

MARY BEARD, R.N.

National Director, American Red Cross

At this time of world crisis nurses have many questions regarding service in the event of a national emergency. An article, "Red Cross Nursing and the Army," in the *July American Journal of Nursing* answers many of these questions.

The scholarship in health education offered annually to a nurse by the Massachusetts Institute of Technology was awarded for the year 1940-1941 to Ruth N. Crawford, executive secretary of the Lehigh County Tuberculosis Society, Allentown, Pa. Miss Crawford is a graduate of the school of nursing of Palmerton Hospital, Palmerton, Pa. She received her bachelor of science degree and public health nursing certificate from the College of William and Mary in Richmond, Va.

PUBLIC HEALTH NURSING

Official Organ of the National Organization for Public Health Nursing, Inc.



*Illustration by Francis Lee Jaques from Canoe Country
published by the University of Minnesota Press*

What gay, tanned faces round the fire!

—Badger Clark

How Can I Serve?

BY THE TIME this editorial is printed it seems rather likely that the United States will be embarked on a program of national preparedness for war. Naturally public health nurses and board members will ask—indeed are asking now: What can we do to serve our country best? These seem to be some obvious steps:

1. For the graduate nurse: enroll in the American Red Cross in the first reserve if you are under forty years of age and unmarried. You can enroll through your local Committee on Red Cross Nursing Service or write to the American National Red Cross, Washington, D.C.

2. Plan to stick to your present public health nursing responsibilities as staff and board members. They are as important as any other work today especially (a) if you are the only public health nurse in your community (b) if you are responsible for a group of nurses or hold a place of unusual responsibility with relation to a special program or agency; or if you are an executive or are in the educational field (c) if you have definite home responsibilities (d) if you have any misgiving about your ability to stand strain, your adaptability to hardship, your health.

In other words, public health nurses should think first of their positions as the shock troops in home defense, and board members should back them in such thinking. It frequently takes the greatest courage and self-sacrifice to remain in the daily routine.

3. Plan to participate so far as your time allows in the other forms of assistance to your country. (See *The Reader's Digest*, July 1940, page 37.)

4. Think of ways in which you can

strengthen your own service to your community. This is a timely chance to form and teach classes in home nursing,* to stress first-aid lessons among school children, among Boy and Girl Scouts, in industry. Every citizen is thinking today in terms of being ready for possible emergency. And the public health nurse, while she need not say this in so many words, can point her instructions toward safer, healthier ways of life—the vital essentials in daily meals, rest, and plenty of sleep as antidotes to jumpy nerves, maintaining normal occupations and recreation as far as possible, and a physical check-up to be in condition to face unexpected demands. Board members can set a good example in this!

5. Be ready to share in any public health program your own state, county, or city may plan. The United States Public Health Service may call on public health nurses for new varieties of service right in their own localities. Refugees may add to our population. These demands may not be as dramatic as was the joining of an overseas unit in the first World War but they are absolutely necessary and a first lien on the experience and time of public health nurses and their boards.

The word as this leaves our national desk on the last day of June 1940 is: Be prepared. Stay where you are. Do what you are doing as well as you can. Make the most of your knowledge of health protection for those around you until a national plan is formed and you are called to serve in it. Then serve.

DOROTHY DEMING, R.N.
*National Organization for
Public Health Nursing*

*See the American Red Cross for recommendations.

The Private Agency Today

By FRANCES P. BOLTON

An address broadcast at the fortieth anniversary of the Instructive Visiting Nurse Society of Washington, D. C., by a long-time friend of public health nursing

BIRTHDAYS are wonderful days, full of gay laughter, of happy ingathering of relatives and friends. They are days of eager anticipation of what is to come, of quiet consideration of what has been, that the years ahead may be rich with the fruit of understanding.

We are here to celebrate—not a first birthday, nor a sixteenth, nor a twenty-first. No; infancy, childhood, and youth have been passed through by our birthday child and the wonderful middle years are coming up above the horizon. We, who are members and friends of this Instructive Visiting Nurse Society of Washington, are met here together to proclaim this anniversary day when our society is reborn into new life, the deepened, enriched life of full maturity; for life—we have been told—but begins at 40.

Forty years. And who knows just how long was the prenatal period that preceded this birth? For nothing in all the world just happens suddenly out of nowhere.

Who can count the men and women who dreamed of a world without pain, a world where all children laugh, where the old folk sit smiling their wisdom to the sun, and youth sings its way into productive maturity? Were they not all precursors of today's programs of public health? Who knows the birth pangs suffered by those who sent the first nurse on her way? And who cares? For like all mothers, once the babe is safely here, the agony becomes the glory of a deeper understanding.

But let us pause a moment and give thanks for those whose dreams bore such fair fruit, asking that we be given wisdom to keep faith with them. They were but a small band of courageous people who dared to take hold of their vision, shape it, discipline it, meet its discouragements, and offer its joys to all who reached out in poignant need. How much we owe them! Yet they ask only that we take hold of that same vision in our turn and fashion it to meet tomorrow's dawn.

A FEW OF THEIR PROBLEMS

Forty years ago there were but 130 visiting nurses in all these United States. Most of these had stepped out into wholly unblazed trails, without maps of any sort. Courageously they had set their feet upon the way and kept their eyes upon the stars. What courage it took!

Have you ever stopped to think of what the problems were with which they had to cope in those early days? They went into the homes of the needy to give bedside care to the sick. Many carried bags of supplies weighing 30 and even 40 pounds. They rode bicycles, they walked, they rode in street cars, in season and out of season, tirelessly pursuing their heartfelt way. And at each bedside there was more than just pain to be alleviated, more than just physical care to be given. The agonized questions of the patient and of the family had to be answered as well: "What does it mean, nurse?" "I can't be sick, there are my wife and kids." "Oh, nurse, I

can't leave my baby—make me well, oh, make me well!" "Show me how to take care of the baby. He frets so. He doesn't eat. He cries all the time and lets nobody sleep."

BIRTH OF PUBLIC HEALTH NURSING

Natural, simple questions. But what momentous portent was theirs, for they had to be answered, and the answering became teaching. And through such teaching the bedside nursing of the first visiting nurses became the public health nursing of today.

Have you talked with some of these pioneer nurses and have they told you what it was that kept their courage high when the weariness of body, heart, and mind almost overcame them? Have you seen the light come into their faces when they spoke of the laymen with whom they counseled, with whom they shared the many problems of their pioneering? They were not alone. They were upheld and strengthened by their boards. For public health nursing whether it was called visiting nursing, community nursing, district nursing, or public health nursing, has been since its inception the combined work of doctors, nurses, and laymen.

EARLY SERVICE WAS FOR THE POOR

Let us look for a moment at some of the differences between the field of service into which the first nurses went and that which is covered today. They were indeed pioneers, these first women who went into the homes of those who were too poor to go to hospitals or to pay for care in their homes. They went, with no special knowledge of community problems, just to give bedside care. They stayed to discover that to teach a mother how to care for her family, a "little mother" to help, were as essential as the original care of the patient himself. They found that even this care and teaching did not solve the problems, for these were often due to broken

families, leaking roofs, open sewers, unpaid rents, inadequate food, alcohol, and drugs.

They were given office space with associated charity agents with whom they discussed the tangible problems of their charges. Some of these problems had to be taken to the police, others to churches, to private individuals, to the schools, and to the courts. Their solution depended largely on the ingenuity of the individual nurse, on her persistence, yes, on her faith, and the faith of her board.

How different now! These 40 years have seen the establishment of departments of health, of outpatient service for obstetrics, of clinics and sanatoria, and of the federal public health service as well. School nurses, industrial nurses, and tuberculosis nurses carry their specialized work. But the family's need is still the unit for which all public health agencies must work, and toward which all efforts must converge. The nurse is the natural interpreter, teacher, friend. The care she gives at the bedside is the key to the heart, to the confidence of the family. What she tells them they believe, for has she not shown them both her skill and her knowledge? Dr. Haven Emerson has said: "Without the public health nurse, the health officer would be as a man deaf, dumb, and blind in relation to the public he must lead to health."

CARE AND TEACHING INSEPARABLE

No plan that separates the actual care of the sick from the teaching for health could give the results that have been and must be increasingly obtained. Let us adjure all those who are in authority in all agencies having to do with public health to keep inviolate this combined service of hand, heart, and mind, lest in an effort toward efficiency of organization the *life* be lost.

These many changes that have brought to our community living what

we all like to believe are more intelligent methods of meeting our problems—our public health departments of every sort and kind—have bit by bit made it appear that private agencies may no longer be necessary; that more people can be cared for by state and federal agencies. On every hand there is also a lessening of private funds and an increased pressure toward government absorption.

Probably much of this is good. But as there is always an impersonality about government, there is a very real danger; for without the nucleus of close personal heartfulness that lives best in our private agencies, the light of public health service will surely go out. Further, government agencies are dependent upon appropriations, and so are subject to insecurity; and men are seldom free from the temptation of misusing power given through control of funds. Dare we subject our people, our sick, to the results of the possible in this important field? Should we not rather insure the existence of privately managed public health nursing agencies that they may be the living heart of the great body of service to our sick people?

PRIVATE AGENCY BLAZES THE TRAIL

I realize that the relative merits of privately and governmentally controlled health agencies is one of the controversial questions of today. I am merely touching upon it as there is not time for a careful presentation of the many splendid arguments on both sides. But I do want to suggest that as citizens, we consider well the amazing contribution made by such agencies as this Instructive Visiting Nurse Society before we destroy them. The trail blazing, the experimentation, the close coöperation between the professional men and women in the active field and the laity—these are the first step to an intelligent, health-minded public. I want to urge that we do not thoughtlessly relinquish

to government those fields that we as Americans hold to be not just the rights, but the responsibilities of free citizenship. Is it not wise to preserve the so-called private agencies lest we lose an invaluable way by which to prove the values of techniques and treatments? Will there not always be need for training grounds, where, as in all private enterprise, the individual takes the risk of the trial and experiment period and after proof, gives it to the Nation?

Standing as we do at this important milestone of our life as a health group, we have no fear of relinquishing to other agencies such parts of our work as can better serve the people by such relinquishment. It is as if they were our children, and we, their parents, rejoice that as living arrows from a bow, they go forth in their own strength. We are perhaps the bow which, as Kahlil Gibran said, God also loves. In its desire to keep abreast and ahead of community problems, the Instructive Visiting Nurse Society has grown to believe that wherever there is sickness there is the need for nursing care and teaching service, regardless of income. So in addition to the work among the very poor, there has been established an hourly home-pay service, based upon the need of the patient and the ability to pay. This service grows ever more acceptable as the physicians introduce it to their patients.

NURSE KEY OF HEALTH STRUCTURE

In closing I must speak of the nurse herself—the nurse who is the key to the whole great structure of our health services.

Granted that money is an essential and that methods for the coördination of public and private agencies must be worked out, the service to human beings is the actuality, and that is the work of the individual nurse.

Any young woman choosing nursing as her profession should be a happy,

healthy, serious-minded creature with a desire to serve her fellow beings, rather than herself. She must be intelligent, for the actual knowledge she must have at her command increases with each fresh discovery in medicine, each change in community methods. Her basic preparation should challenge every phase of her being, and the special work she will need to equip herself for the public health field cannot be belittled.

We may have the happiest coöperation with the department of health, the local hospitals, and the private physicians. We may have coördinated our work with that of the tuberculosis, syphilis, and cancer clinics, and with the new psychiatric groups. All these may be in our structure, but if the nurse is not of the highest caliber, if she is inadequately equipped, we cannot function. Is that not so?

GOOD PREPARATION INDISPENSABLE

We, in the public health field, must help draw into the nursing schools young women of high standards and fine quality. We must see to it that these schools are adequately financed so that they may give the kind of basic preparation upon which specialized work can be built. And somehow we who have served these many years and know the pitfalls and dangers of a too-swift expansion must find ways to convince those less qualified by experience to measure these dangers, that too much dilution ruins the effectuality of the best medicines, and that building too hastily will prove to be building upon the sands.

It is the visiting nurse who sees tuberculosis, cancer, syphilis, and pneumonia in the first, curable stages. But

she must be trained to recognize them and then must persuade the individual to get the help that modern medicine has to give. It is the nurse who must know the community agencies so well that no moment is lost, for those lost moments take their toll in lives.

So here we stand at this wonderful fortieth milestone looking back, with both pride and humility of heart, at the work done; looking forward with high hope and fresh courage to whatever the future may hold.

We are ready to assume our rightful part in whatever changes need to be made that ever more and more people may have health. Indeed, we are constantly reaching out into the future as we have been given light to see it, adapting and readapting our methods to the fast-moving changes of this changing world. We should be faithless to the trust that is ours did we not move out into the ever-changing stream of today's living. Board members, nurses, physicians, and laymen who help carry this Society—we all know that underneath the surface of various methods of public health services there is in every heart the fundamental desire to alleviate pain, to build health of body and mind for every child of the future.

So on our birthday let us remember that Nature builds slowly those things which endure, and that she makes ample preparation for each fresh growth—that as we move forward we may build surely, strongly, wisely for Tomorrow's Dawn.

Presented over Station WOL, Mutual Broadcasting System, Inc., Washington, D.C., April 30, 1940.



The Health Council

By IRA V. HISCOCK, Sc.D.

Through a representative health council the community can study its problems, achieve better understanding and work toward a coördinated community health program

IN THIS critical period of strife and unrest throughout the world, with great competition for public attention, it is gratifying to observe in the United States an increasing public interest in matters relating to health. Those of us directly engaged in public health work have an unusual responsibility to insure that our programs are soundly conceived and ably executed.

Problems of a continuing democracy are directly related to the opportunities for growth and development for the welfare of our people. There is renewed interest in the appraisal of needs and resources. There is a wider realization that the proportion of the tax dollar and of private funds devoted to public health in general and to public health nursing in particular is still relatively small in comparison with other community activities and in relation to possible dividends. There is a growing demand for an increase in health services. Public health education is advancing. Could there be a greater challenge for foresight, for coöperative planning based on facts, for statecraft and wise action?

Teamwork is essential for progress. Certain basic principles and premises which are usually accepted in theory deserve increasing attention in practice:

1. The family is the biological and sociological unit for a health service, whether our immediate attention is focused primarily on a problem of maternal or child health, or tuberculosis, or syphilis, or cancer, or a home accident. The family should be visualized as a

whole; and certainly the individual should be visualized as a whole. A good educational case-work job requires this emphasis.

2. In planning a balanced program, the community—made up of families of various characteristics, and of many civic, educational, and industrial enterprises—should be considered as a whole after the parts of the administrative and social structure have been studied. Features of the program must be adapted to the needs of districts or neighborhoods, which may present problems almost as varied as are those of families within the community.

3. The objective of public health, with its many functions, must be visualized as a whole. This requires coöperative action on the part of many agencies and individuals rather than the pursuit of an independent course without vigorous attempts to facilitate integration of specialized interests. For example, we are all interested in the health of the child of school age. This common purpose cuts across the special interests of some fifty national agencies which can meet on the same ground with their efforts directed toward this goal.

4. There is an increasing realization of the close association of health and social factors. A community may lack a comprehensive program of health education. But application of the techniques of health education may be fruitless unless there are basic resources available for medical and nursing care, dental hygiene, mental hygiene,

and nutrition, together with sound administrative programs for public health and social service.

5. For economy, efficiency, and enjoyment in the rendering of public health services, there must be:

Clarity of purpose.

A minimum of duplication and overlapping.
Alertness to close existing gaps.

Avoidance of friction and vested interests.

Reduction of individual drives, disconcerting to the public and discouraging to the workers, coupled with the development of some plan to meet the problem of competition for board members, for funds, and for public interest and good will.

Promotion of influence and strength through joint study and planning.

NEED FOR SHARING EXPERIENCES

There is need for some means by which it is possible to meet our fellow workers, to discuss problems of mutual interest, and to gain inspiration through sharing experiences. This need is partially met in a specific field of activity through the organizations of the local, state, and national agencies. The national agency helps:

1. To increase the effectiveness of local programs by the development of standards.
2. To spread the scope of influence.
3. To make available the cumulative experiences of many groups.
4. To evaluate programs objectively.
5. To weigh the results of local trial-and-error methods.
6. To provide general aids.
7. To secure trained personnel.

The local and state agencies in turn can keep the national agencies informed of new types of problems, of results of special studies or experiments, and of trends. Understanding and coöperation between these groups are obviously essential.

"Increased stability and prestige come to any local organization through its membership in an established national agency, a membership which helps to hold each local unit to standards of work, and because of the work and reputation of the national body,

helps to interpret the local agency to its own community as well as to enlarge its outreach and increase its vision."¹

NATIONAL AGENCIES COÖRDINATE

There has been some experimenting with coöperative projects at the national level in the direction of utilizing existing organization to meet new needs. For example, fourteen national associations have worked together through the Committee on Care of Transient and Homeless. The coöperative planning of measures for the control of syphilis and gonorrhea by the United States Public Health Service, the American Social Hygiene Association, and the American Medical Association is a good illustration of teamwork between public and private agencies. Three national organizations in the nursing field have been working through a Joint Committee on Community Nursing Service for the better coördination of all nursing services in local communities. The National Health Council was organized to aid in the promotion of health throughout the nation and to that end to assist the various members of the Council in their respective health promotion activities and to coördinate the activities in the interest of efficiency and economy.

THE HEALTH COUNCIL

The health council plan of voluntary coöperation has been valuable in several communities, especially in such cities as Boston, Cincinnati, Cleveland, and Louisville. Sympathetic coöperation of a constructive nature is essential if community health and welfare organizations are to serve the public most effectively. As the public health program has broadened with the introduction of new lines of service and the emphasis on education in the principles of hygienic living, consideration has naturally been given to the relative values of different health activities. The

health council plan was developed to meet the local needs for a coordinating and supporting voluntary body of representative public-spirited citizens.²

The first health councils were organized more than twenty years ago.³ There are seven councils organized along lines recommended by the National Committee of Health Council Executives. One of these is called a health league, another a health federation. In addition, there are at least fifty coordinating health agencies, usually health divisions or committees of councils of social agencies, in as many cities. At least two states, Indiana and Massachusetts, have state health councils.

The purposes of the health council are primarily to promote the coordination of public and private health work and to aid in securing continuity of program; to serve as a forum for discussion of health and sickness problems, policies, and plans; to develop new standards of service and to improve present standards through joint study of special problems; to secure improvement in existing health facilities and services and the establishment of new or additional health facilities or services when needed; to prevent duplication of effort; and to give moral support to the department of health, in cooperation with the medical, dental, and other professional societies.

A health council functions by developing better understanding among the official and voluntary health agencies of a community.* Through special studies by executives and committees, many community health problems can be analyzed and much assistance can be given to the health officer, who participates actively in this cooperative enterprise. Through such studies and

joint planning each agency may determine its proper place in the community program.

A health council must be thoroughly representative of the recognized health forces of the community.** It should have among its members lay people; representatives of the official health agency or agencies, of organized medicine, of organized dentistry, and of organized nursing; and representatives of the nonofficial agencies interested primarily in public health work. It should be without limitation as to race or creed. Liaison with recreational and welfare organizations is essential.

The form of organization and operation of a local health council will vary in details, depending upon local conditions. In larger communities there will be need for a full-time staff and a budget. In smaller communities the health council may utilize such part-time service of other staffs as may be available; for example, the services of members of the staff of a council of social agencies, a health department, a tuberculosis association, or other agency. The housing of two or more health agencies including the health council under one roof also facilitates cooperation and tends to promote understanding between the workers.

THE SMALL COMMUNITY

In small communities—including a rural area or a county having only a few health activities, such as a health department, a school health program, a medical society, a visiting nurse association, a tuberculosis association, and possibly others—there is need for coordination of health activities, as well as in the larger cities. Some executive service is essential to the most effective health council program. The selection

*One council has the following divisions: nursing, health education, child hygiene, cancer, clinics and dispensaries, housing, tuberculosis, social hygiene, mouth hygiene, mental hygiene, among others.

**This outline of representation and organization is essentially as prepared by the National Committee of Health Council Executives.

and appointment of the executive should be the responsibility of the health council with the coöperation of the other local agencies.

A health council, to function properly, must have full scope to determine its own policies consistent with accepted public health principles.⁴ Its organic relationship with the council of social agencies may vary in different communities, but the health council should work in coöperation and harmony with both the council of social agencies and the community chest or fund.

RELATIONSHIPS OF NURSING AGENCY

Considerable attention has been given by public health nursing organizations to their relationships with other community agencies. Public health nursing is closely related to the activities of several other professions and many community organizations, and "cannot be carried on successfully and productively as an isolated service. The more closely it is coöordinated with the interests and activities of other related and coöperating agencies through a constant sharing and interchange of ideas and service, the more soundly and economically will it fulfill its purpose."⁵

The closest coöperation between family case-work agencies and the public health nursing agency is essential if the best results are to be accomplished for their common goal. The council of social agencies and the health council offer an opportunity for the various agencies to work together. In a rural community, the nurse will not often find such councils, but she will have one or more public and private agencies with which she can coöperate for an effective family health plan, and may also avail herself of the services offered by state-wide agencies.

The use of a nursing council has been suggested in the *Manual of Public Health Nursing*:

Just as a health council forms an excellent

machinery for planning and coöordinating all public health efforts in a community, a nursing council can help to study, improve, and coöordinate all activities related to nursing. It also makes possible joint planning by those who render nursing service and those who are its consumers.

In some communities, such a nursing council functions as the nursing committee of the health council. Sometimes the nursing council is an independent unit with membership chosen so that each council has representation on the other.

The membership of a nursing council should include representatives from all agencies administering or distributing nursing service; from organized professional groups, such as medical, nursing, and social-work groups; and from lay groups. It is often best to start with a rather small committee and to increase the number of members as the program develops.^{6, 7}

THE SOCIAL SERVICE EXCHANGE

As emphasized in the *Manual of Public Health Nursing*, when a community has assumed its social responsibilities to the extent of supporting organized social and health work, a social service exchange or central index becomes a necessity for successful coöperation among community agencies in giving the best possible health service to the family. Such an exchange or index functions as a clearing house. It registers all cases about which an agency has information which might help another agency in serving the family better; and it should be actively utilized by all nursing agencies.

Finally, reference should be made to public health education, an activity which permeates the whole health field. Probably the strongest potential ally of the health department in its program of health education is the public health nurse, for it is she who sees the greatest number of people in intimate contact. In home visits for communicable disease or to give bedside care, in schools, and during clinic hours, she meets the people who most need health guidance at the time they are most likely to accept and profit by sound instruction.

The enlistment of community forces for the purpose of health education requires organization in order that all groups in the community may be reached and the activities of the various agencies correlated. Advance preparation of a carefully considered program is essential. The basis for program-making is a study of the community to determine the major health factors involved, the public responses desired, and the necessary procedures. The objectives should then be definite and reasonable, and they should have importance locally. There are effective tools, many of which are utilized by public health nursing agencies, for rousing interest and thereby spreading the information which is needed.¹

The final test of health education is not how much information is distributed, but the extent to which behavior is influenced. United action can best be secured through the creation of some sort of coordinating body, such as a health education committee of a health council. This consists of a central group of staff and board members of health and welfare agencies who are active in projects for health education within their respective organizations. The committee can bring together the representatives of medical, health, and dental organizations, and leaders in social agencies, women's clubs, parent-teacher associations, the Junior League, civic clubs, schools, and churches. The

committee members, besides aiding in community planning, will carry useful ideas back to their own groups and thereby spread the health message and develop a better understanding of programs and community needs.

In conclusion, we have reason to be proud of the strides which are being made in the advancement of public health, especially in the field of public health nursing. Experience has shown the importance of visualizing the family as a unit and the community as a whole, and of recognizing the close interrelationships of various health and social factors in community life. The health council provides an opportunity for us to work together in the community and to present a united front for public health with its various parts properly related—an objective worthy of continuing effort.

Compulsion can under no conditions work the changes we want to see wrought by the obedience of consent. Where power cannot reach, "influence" wins her way, and where the rigid law stops dead, there a public opinion, active, intelligent, and educated works wonders by creating obedience by consent. Here county councils, district councils, parish councils, may we not add "family councils," will all cooperate to give to each man and woman the chance to take his or her part in the great march forward, onward, and upward that is to lead us to the higher life.²

Presented before the N.O.P.H.N. General Session, Biennial Convention, Philadelphia, Pennsylvania, May 14, 1940.

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⁴ For a description of hospital councils, see Report on Hospital Councils, Their Functions and Organization. The Transactions of the

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⁷ For a suggested guide for the formation

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⁸ Hiscock, Ira V., Connolly, Mary P., Delavan, Marjorie, Patterson, Raymond S., War-

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NATIONAL CITIZENS' CONFERENCE

SPONSORED by the Community Chests and Councils, Inc., and attended by more than 400 chest directors and guests, the two-day National Citizens' Conference in Detroit, Michigan, May 24-25, presented for discussion the important question: "Are we making the most of the welfare dollar—private and public?"

At the opening session the keynote was sounded when the chairman said there was need for educating the public to think of a chest, not in terms of dollars, but in terms of purpose and results. Interesting discussion centered around four charts on: (1) per capita expenditure for health and social welfare (2) family welfare and general dependency (3) care of children (4) free hospital care. This discussion led very fittingly into an excellent report on the recent Kansas City (Missouri) Survey made under the auspices of the Community Chests and Councils.

Earnest planning was done at six round-table discussions, each approaching from a different angle the question, "How can we make the most of the welfare dollar?" Some of the chief causes of waste in spending the welfare dollar were analyzed. So evident was the need for a study on community budgeting that there was a request for such a study to be made and discussed at next year's meeting.

Suggestions were given at a luncheon session on how social workers could show proof, as public health workers

already do, of the worthwhileness of preventive work. The Stamford (Connecticut) plan for community action in relation to a family situation, to discover early the places where social breakdown is threatened and to "bring together systematically on each case the combined service of our separate specialized agencies," was commended by Bradley Buell. He ended his remarks with: "Prevention of social breakdown must be a community action."

Those who raised questions on foreign relief at intervals throughout the meetings were told to bring them to the last session. So, it was not surprising that the last session was a large and spirited one. The work being planned and carried on in Europe was summarized by Eliot Wadsworth, a representative from the American National Red Cross, who was introduced by Robert Cutler, the newly elected president of Community Chests and Councils. Since the speaker admitted that all phases of relief were not being covered by the American Red Cross, there was general agreement that the work of all groups administering foreign relief should be coördinated and that there should be assurance that all phases of relief are being covered. After a brief presentation of various relief problems, it was voted that a resolution be sent to President Roosevelt urging coördination of appeals for foreign relief funds and rendering of foreign relief services under the natural leadership of the Red Cross. L. H. R.



WOODEN DOLLS FOR EXHIBITS

A DIORAMA of nine scenes showing the work of the 40 visiting nurses of the Rochester Public Health Nursing Association was prepared by the Publicity Committee for the annual meeting at the organization's twentieth anniversary in 1939. The little jointed wooden dolls were made by the Industrial Workshops, Inc., a non-profit making organization for the rehabilitation of patients. The Publicity Committee dressed them, built the rooms, and made the furnishings. Each little box was lighted. The scenes were labelled as follows:

1. Calls are received by mail and telephone.
2. Neither storm nor rain nor heat nor snow . . . tasks.
3. In mask and gown she cares for scarlet fever.
4. Repeated massage brings happy results.

5. An hour's daily care keeps him comfortable.

6. Young mothers are taught infant care.

7. Nutritionist teaches preparation of special diet.

8. A volunteer group works in the supply room.

9. Expectant mothers' class.

The exhibit has been placed at the Academy of Medicine and comprised a part of the health exhibit of the Council of Church Women's Winter Exposition. It has been borrowed by groups for the purpose of explaining the nursing service available for Rochester.

The dolls are dressed and come in two sizes. The six-inch size sells for 35 cents each and the eight-inch size for 45 cents each. One month's notice is necessary for filling an order. They are obtainable from the Industrial Workshops, Inc. (non-profit making), 292 Alexander Street, Rochester, New York.

The School Panel at the Biennial

THE PANEL on the school child at the Biennial Convention proved to be popular beyond all expectations of its planners. The audience overflowed the South Garden of the Bellevue-Stratford Hotel and many were turned away.

In a spontaneous discussion that did not drag for an instant, ten participants exchanged ideas on the question, "How Can School and Community Join Forces to Serve the School Child?"

The panel was opened by the chairman, Geraldine Hiller, who presented several questions to start the discussion:

What are the health needs of the school group?

Should we speak of physical health and emotional health, or should we regard the child in reference to his whole being, and not try to separate this being into parts?

Who should be responsible for the health examination of children in the community?

Is a healthful environment provided at home and at school? What recreational facilities are provided?

What constitutes a "proper" environment, and what is "wholesome" recreation? Are these the responsibility of the school?

Some of the high points of the discussion are summarized as follows:

Because school health work is often thought of as a specialized service it is frequently omitted from community planning. It has become closely associated with education and frequently education is in an ivory tower, set apart. School health work is a community service and as such should serve the school-age group in coöperation with all agencies.

The health needs of the child can be brought to the attention of the community only after the health examination, for which the family and school physician should be responsible. There should be joint planning for this activity,

with the local medical group acting in an advisory capacity.

Health is considered in its broadest sense to include mental, emotional, physical, and social factors which are necessary to enable the child to develop to his utmost capacity. Parents do not always understand this meaning of health and it is necessary to enlist community resources for public health education.

Coöperation between home, school, and community agencies is necessary as the foundation of a purposeful, adequate program of health education. The school cannot function alone.

This coöperative planning is to develop a program to serve the needs of the children—not for the perpetuation of any organization. It is to help each organization serve the community more efficiently. The functions of organizations may even be changed.

The question was raised: What agencies in the community do we expect should contribute to the development of normal, happy children? Obviously not all groups and all individuals participate equally. Who should take the initiative in forming the group for coöperative planning? Who should be invited? What can be done in smaller communities where there are few agencies?

If no other group wishes to initiate the program the school should take the lead. It is a good idea for the school to be the place where community activities are carried on. Too often the buildings are not used for this purpose. They should belong to the community to use whenever necessary for the good of all.

Another question was raised: Is it necessary to have an ideal setup for good community planning? How can existing resources be used to the best advantage?

Since the object is to remove deficien-

cies in the community, action and not talk is necessary to create a better place to live in, where children may grow into good citizens. We must see that each boy and girl develops ideals he or she can hold on to in a crisis. How can we develop these ideals when a community has no facilities for play, where there is poor housing, and where the guidance program is curative instead of preventive?

In community planning, the home must be considered. Frequently agencies do too much for people instead of stimulating them to act for themselves. In the final analysis the burden of responsibility rests with the mothers and fathers of the children we are trying to serve. They can help by participating in planning for the benefit of their children, through groups such as the parent-teacher association, nursery school, or open forum.

Each agency should be aware of the contribution it can make to the program.

In an effort to determine needs—both health and social—of the child in the community, a community survey might be undertaken by interested groups. After data from a survey are gathered, proper leadership should be assured before any ambitious program is undertaken.

The democratic way of attacking problems in a community is for interested people to come together to talk over needs. This coming together might easily be accomplished by developing community councils, which should have representatives from every health and social group in the community. It has been said that the test of such an organization is the action resulting therefrom.

A question was asked from the audience: How can a community council be formed in a rural area?

The suggestion was made: Call upon interested individuals in the community and secure the advisory help of state

consultants. Use the consolidated school building or homes in the neighborhood for meetings.

Another question was asked: Isn't this a big job for a public health nurse to initiate?

Dr. Emily P. Bacon replied that the nurse is equal to it and suggested that very often she is the logical individual to start such a program since she is fully aware of the needs of the school child.

Another question from the audience was: How do you teach children the democratic way of life?

Suggestions were: through social studies taught by a teacher without prejudice; through contacts with individuals who will be fair and understanding with the child and his problems; through the development of a community which will supply the incentive to follow the democratic way.

A summary and comments were presented by Ignatius D. Taubeneck, director, Bronxville Community Forum, and lecturer in contemporary problems, New York University, New York City.

Those taking part were:

Geraldine Hiller, R.N., chairman, Nurse-Teacher Group, Public Schools, New Rochelle, New York.

Emily P. Bacon, M.D., Philadelphia, Pennsylvania, representing family physician.

Mary B. Hulsizer, R.N., supervisor of school nursing, Department of Health Education and Service, Board of Education, Newark, New Jersey.

Bertha Jenkins, R.N., educational consultant, Bureau of Nursing, Department of Health, New York, New York.

Frances Titus, R.N., supervisor, Division of Public Health Nursing, Nassau County Health Department, Mineola, New York.

Walter S. Cornell, M.D., director of medical inspection, Public Schools of Philadelphia, Philadelphia Board of Education, Philadelphia, Pennsylvania.

Robert R. Hartley, minister, First Presbyterian Church, and president, Council of Social Agencies, New Rochelle, New York.

Edwin D. Solenberger, general secretary, Children's Aid Society of Pennsylvania, Philadelphia, Pennsylvania.

Telling Our Story Through Radio

By ANNE M. LAWTON

A specialist in radio publicity discusses four types of radio programs used by nursing agencies and gives helpful suggestions on the preparation of radio copy

RADIO is one of the greatest social forces that has ever been given to mankind. And a rare opportunity is ours who have a chance to use it, not only because of the great audience we may reach but because of the chance of talking to that audience when they are relaxed, free from the self-consciousness people have in public, in the privacy of their own homes where they are themselves without pretence or sham, receptive to our story.

The privilege of talking to these people in these surroundings and in this frame of mind is a very great one. But it must be used with the utmost taste and delicacy of handling.

It is your desire to create a feeling of friendliness toward and an understanding of the splendid work you are doing. This friendliness and understanding will give those who need your service confidence in it, and will give everyone else a sympathetic interest in your work and a desire to coöperate with you not only during a campaign for funds but at all times.

You do not have a great deal of money to spend on radio, and the problem is how you may use the time given to you most effectively.

TYPES OF RADIO PROGRAMS

There are a number of types of radio programs you may employ—the dramatized skit, the interview, the short talk, and the spot announcement.

The dramatized skit is dangerous for many reasons. First, in order to be ef-

fective it should be done by professional talent. The programs on the air today are so good that even those people who tune in on their local station a big part of the time also listen to the network shows, and they have become very critical of the programs they listen to. If what they are listening to does not come up to their standard, they can with the turn of the dial get something that does.

If you turn your skit over to the station to produce, the staff are busy people who have little time to rehearse it with station talent, sound effects, and the things that go to make a creditable radio production.

Of course, it is possible that you could put on a skit very successfully, but our experience has shown us that the chances are slim and we believe there are ways you can much more successfully tell your story.

The interview type of program is a much safer choice than your skit. You can get the station announcer or some prominent member of the town to interview one of your nurses. Have her tell some of the interesting, exciting, and human things that happen in her every day work. You have real adventure and drama to draw on. Don't hesitate to use it.

The short talk is effective also. If you have an opportunity to talk on the radio, just remember that you have a wealth of real human interest material in your files. Get out one of your case histories and read the story without identifying

information. Forget that you are talking to a large audience and try to picture yourself talking to a small family group—perhaps that of your best friend—sitting around the radio in the living room.

The basic appeal of radio is to the emotions. Its programs bring laughter, excitement, pathos, and stories of love and longing into the living room. The effectiveness of its appeal to the emotions is enhanced by the fact that the listener is at home, freed of the emotional restraints of public contact. An example of what I mean is the plea Alexander Woollcott makes once a year for the work of the Seeing Eye.

In a most understanding and skillful manner he gives the radio audience a picture of what these dogs do, and how wonderfully they bring mobility and security to the lives of the blind. He explains that the organization needs funds to continue its work, and asks those who feel like contributing to do so. As a result, thousands and thousands of dollars pour in every year to help this splendid organization continue its work.

This is but one of almost innumerable instances of the quick and generous response of the radio audience. People usually are kind and helpful. And they recognize and appreciate it in others.

So when you have an opportunity to give a radio talk on the work you are doing in the community—don't worry about not having time to get in touch with your national organization. After a brief introduction read one of your case histories—again without identifying information—in a simple, sympathetic manner. Let people see you are doing a really fine work and that you stand ready to help them if they need you.

And in giving your story don't hesitate to localize it. People are always particularly interested in what is going on around the corner, down on Clover Street or at the other end of town. And

if, for instance, your story is about a little girl who was crippled from infancy and is now able to run and play with other children, give your audience the feeling that they know that little girl before you have finished. If she has deep blue eyes and golden hair, or those soft brown eyes that just about break your heart, tell them about it. If she was particularly courageous and eager to cooperate in getting well, let them know that too. All such things will appeal to your audience and make them love not only the youngster, but you for telling them about her in so understanding and sympathetic a manner.

THE SPOT ANNOUNCEMENT

And now we come to the spot announcement—which I feel should be the mainstay of all your radio broadcasting. Some of the most successful radio advertising done today is done through this medium. The spot announcement is that sentence or two between programs which may be anything from a time signal to a statement that Johnson's fluffy lemon pie will make an ideal dessert for dinner.

The one message you get across with your five-, ten-, or fifteen-minute talks can be divided up into a great many messages with the twenty-five, thirty, fifty, and hundred word announcement. And you not only get greater frequency but undoubtedly better time. Twenty-five or thirty words before such programs as Information Please, Fred Allen, Bing Crosby, and your more popular daytime programs naturally get a much greater audience than a fifteen-minute program that is given at some less desirable time during the day when the station has nothing scheduled.

Naturally, you cannot tell your whole story. But in twenty-five words, for instance, you can tell one thing you do with a "Do you know" beginning, and end up with an offer of service and your telephone number.

And I can assure you the stations will appreciate your spot announcement copy. Several years ago we wrote our first copy—spot announcements—for the United Charities Campaign in Philadelphia. The stations actually thanked us for the material. The program director of one station in the city said: "This is the kind of thing we can use—it's ready to put on the air any free minute we have. We have got so many half-hour plays submitted to us for use, and we simply can't use that kind of material. We haven't time. But feed us this kind of stuff as long as you want." And half your battle is won when the radio stations are enthusiastic about your copy!

THE LONGER SPOT ANNOUNCEMENT

Moreover, when you are preparing your longer announcements of fifty and one hundred words, make sure they are interesting and will hold the attention of your listener. Remember that these announcements go on the air absolutely cold, with nothing to support them. Don't use unnecessary words. Be sure your lead contains real appeal. Read your copy out loud after you have written. If it does not sound right, keep after it until it does.

The following announcement was given me for comments and editing:

When in need of a part-time nurse, remember that the Midtown District Nursing Association is prepared to furnish you with just that kind of service. By calling their headquarters at 187 Middle Street, 4-2411, you can make an appointment for a nurse to call at a definite time for a surgical dressing, to give a daily bath, or to render any nursing care that may be needed, under the direction of your physician. Many people think of the Midtown District Nursing Association as being a charitable organization only. While it is true that the district nurses make an average of 400 free visits a month, they also maintain an hourly appointment service by which they call on you at a stated time each day. The charge for this is \$1.50 for the first hour, 50 cents for each additional half hour.

Is there someone in your family just home

from the hospital who needs a surgical dressing each day, but who does not otherwise need the services of a nurse?

Have you a chronically ill patient in your home who would be benefited by a nurse's care for one hour three or four times a week?

Then, call the District Nursing Headquarters at 187 Middle Street, 4-2411, and talk your problem over with them.

They are there to serve you!

In the first place this announcement is too long. Its writer has tried to crowd too much into one story. Your free service and your pay service are each stories in themselves. Don't confuse the listener by giving him a smattering of each in one announcement.

The wording is stilted and unnatural. It is not particularly pleasing to the ear. It is difficult to read, which means your announcer cannot give it the expression and emphasis it should have.

And we have found that when you give the listener a telephone number it makes him feel more at ease if you give him a name to ask for. If he calls Miss Jones, Miss Fox, or Mrs. Maron he will feel much more at home and be ready to tell his story or make his request without embarrassment or hesitation.

The following announcement tells the story pleasingly and in much fewer words:

Is there someone ill in your home today? Your little daughter, perhaps, who isn't sick enough to require a full-time nurse but who does need quite a bit of nursing care? This situation occurs in most homes at some time or another.

And here's something you'll be glad to know when it happens in yours! The Midtown District Nursing Association stands ready to supply you with a part-time nurse—a nurse who will come into your home by appointment and give skillful care to the patient under the supervision of your own physician.

And she is available for a very moderate charge—\$1.50 for the first hour and fifty cents for each additional half hour.

So when there is someone ill in your home—don't wear yourself out with the anxiety and strain of taking care of him. Telephone Miss White at Jefferson 4-2411. Ask her to send a graduate, registered nurse to your home. Remember—telephone Jefferson 4-2411 and

ask for Miss White when you need a part-time nurse.

FIVE STEPS

In writing radio copy there are five steps I cover before completing a commercial:

1. Attract attention.
2. Arouse interest.
3. Create desire.
4. Implant conviction.
5. Move to action.

In your broadcasts you may not want to use all of these, but they will serve as a foundation to build your announcement on. If you will proceed on this basis and keep your copy in a conversational tone, you will come pretty close to what you want.

There are many times when an interview or a fifteen-minute talk can be worked in with your spot announcements very effectively; for example, at campaign time when the town or city is campaign-conscious, or during some epidemic when illness is on everyone's mind and tongue. But such a talk will not get so enthusiastic a reception in the summer time when most of us are healthy and well. Another time when a longer talk is effective is during a flood

or other disaster. To come on the air at a time like that and give frantic parents easy, simple instructions on how to guard against sickness, or explain the necessity for boiling the water will do much to build lasting friendship and good will. At other times, however, you take a chance of having the dial switched from a perfectly grand story or interview. People live pretty much from day to day, and until they need a public health nurse I'm afraid they don't think much about her.

But if you will keep pounding away with your short announcements containing instructive information on what you are doing and are eager to do, people will soon look on you as a friend, and will be ready to receive your longer programs when you put them on.

And when you prepare that speech or interview just remember that your audience is not 100,000 or 500,000 people but a small family group sitting about the radio. That will make it easier for you and I am quite sure the broadcast will get a much more sympathetic and enthusiastic reception.

Presented before the N.O.P.H.N. Round Table on Radio Publicity, Biennial Convention, Philadelphia Pennsylvania, May 16, 1940.



THE BENEFITS OF SALT IN HOT WEATHER

When temperatures are high and people perspire freely, heat prostrations may result if the salt and moisture lost in perspiration are not replaced regularly and in adequate amounts.

Industrial plants such as steel mills, in which men work at excessive heat, learned some years ago that the simple expedient of providing salt tablets at drinking fountains would reduce heat

prostrations among their employees.

The general public can well profit from their experience. When the thermometer soars into the nineties and higher this summer, sprinkling extra salt on foods to replace the salt which has been lost, and using generous amounts of drinking water or other liquids should prove helpful in avoiding danger from exhaustion during the hot spell.

—From *Nutrition Notes*, June 1940.

The State of Our Finances

By W. LAWRENCE McLANE

The treasurer of the N.O.P.H.N. reports to the membership on the organization's finances at the 1940 Biennial Convention

I CONFESS that my presence here this morning speaking before such a gathering of the fairer sex reminds me of a story, which many of you have undoubtedly heard, of the man who was about to undergo a surgical operation.

He was lying on a stretcher in the anesthetizing room adjoining the operating room, where unfortunately he could hear muffled voices and the occasional clinking of surgical instruments, when the surgeon who was to perform the operation on him walked over to him. The patient said, "Doctor, you know this is only the second operation that I have had and I am very nervous about the whole situation." Whereupon the doctor turned to him and said, "Don't you worry about it, old man, for I am twice as nervous as you are, as this is my first operation."

This seems particularly applicable to the present predicament of your treasurer, as I confess this is the first time that I have ever had the occasion of addressing so many ladies without a little moral support by at least seeing a few men way in the back of the hall.

The treasurer of an organization such as the National Organization for Public Health Nursing, with members located from the Pacific to the Atlantic, from the Gulf of Mexico to the Canadian border, Alaska, and the Philippine Islands, has of course had the opportunity of meeting only a very small percentage of the membership, and I welcome this opportunity to meet more of you.

It is a pleasure for me to report that your organization ended the year 1938 with an excess of income over expenses of \$4036.04, and for the year 1939 an excess of income over expenses of \$1916.86.

In spite of this favorable showing on our profit and loss statement, I feel obliged to insert a note of warning. I hesitate to in any way cast a pessimistic note at this time, but I would not be fulfilling the duties of my office were I to let this occasion go by without touching on the question of contributions.

I fully realize that this group which I am now addressing is the backbone of this fine organization, and that you never cease striving to add new members and to spread the gospel of this organization, but unfortunately over the past two years our contributions have decreased rather than increased:

In 1935 there were 273 contributions, totalling \$42,340.

In 1936 there were 298 contributions, totalling \$30,028.

In 1937 there were 332 contributions, totalling \$29,384.

In 1938 there were 264 contributions, totalling \$22,832.30, which included grants from foundations.

In 1939 there were 264 contributions, totalling \$19,090.50.

Now, I fully realize that an organization such as the N.O.P.H.N. lacks the personal and emotional appeal which can be so graphically set forth, let us say, by a hospital that can issue pamphlets with photographs of operating rooms or ambulances arriving at scenes of disasters or by institutions caring for crippled or blinded persons, offering tremendous photographic appeals; or by the Red Cross or the Salvation Army. For it is almost impossible to depict graphi-

cally the magnificent service that the N.O.P.H.N. renders to the staffs of our agency members. This matter of appeal has been a great source of worry and has been discussed at length by your Finance Committee. We have found only one solution to this problem and that is the spreading of our story by word of mouth. As I have stated previously, you women coming from all parts of the world over which the American flag flies must know of individuals in your communities who, if approached by people like yourselves who are thoroughly conversant with the functions and needs of the N.O.P.H.N., would gladly give annually and substantially for the continuance and further enlarging of the field of this work.

I want you to clearly understand that I am not in any sense of the word implying that you make an additional contribution yourselves—you are doing enough already. But I would like to leave one thought with you, which possibly might be of assistance in procuring contributions. With the ever-increasing burden of taxation, I doubt if many of the laymen whom you might approach for a gift realize that the N.O.P.H.N. gets not one cent from federal or state funds derived from taxation, and further that a contribution to the N.O.P.H.N. can be deducted from his or her income tax return.

I do hope, therefore, that you will find it possible and will endeavor to procure additional contributors when you return to whatever part of the country you are from. I will discuss this matter no further as I feel sure you all understand our situation and the trend of the times.

Our surplus over the past two years

was due in no small way to the tireless efforts and coöperation of the staff in watching expenses, for which I want to record publicly the sincere thanks of your treasurer. Therefore, your Finance Committee decided that this coming year, January 1 to December 31, 1940, it would recommend budgeting a slight excess of expenses over income in view of our net figures of the past two years. For should we fail to increase the income to meet the approved increase in budget, we have sufficient reserves from which this deficit could be met for at least this year.

Speaking of deficits reminds me of the story of the treasurer of a certain church, who when making his annual report to the vestry was greatly embarrassed by the fact that he would ultimately have to inform them that they had a substantial deficit for the past year. At the end of a very confusing and lengthy report incorporating numerous figures which he hoped would confuse his audience, thereby hiding the bad news, he sat down. An elderly lady, one of the staunch pillars of his congregation, who with advancing years had become quite deaf, rose to her feet and moved that a vote of thanks be extended to the treasurer and that half of the deficit be sent to the Red Cross!

In closing, let me express to you again my real appreciation and pleasure in being here today, and the hope that the slogan that will be carried away from this Biennial Convention will be, "Match every membership with a contribution."

Presented before the N.O.P.H.N. business meeting, Biennial Convention, Philadelphia, Pennsylvania, May 14, 1940.

Following this report of the treasurer at the business meeting of the N.O.P.H.N. on May 14, the membership voted to authorize the Finance Committee to consider the establishment of some type of "sustaining membership" through which members who wish to make a regular contribution in addition to the regular \$3 membership dues may do so.

A Nurse at the Conference of Social Work

NURSES WHO were fortunate enough to attend the National Conference of Social Work in Grand Rapids, Michigan, on May 26-June 1, were exposed to a cross section of social thinking such as can exist only in a democracy. Surely in no other gathering can be found such a broad range of viewpoints and such ability to disagree amicably while uniting on certain common goals. Where else would one find at a single conference a meeting of sixty groups which includes the American Association of Social Workers, the Salvation Army (whose uniforms dotted the sessions everywhere), the Association of the Junior Leagues of America, the American Legion National Child Welfare Division, and the Joint Committee of Trade Unions in Social Work?

A cynic might say that the conference of 6500 people is top heavy; that they meet in different sessions as separately as if they were in different cities; that the unity is superficial. To some extent this is true, but one observes before the week is over that these widely divergent groups overlap, and by the process of free discussion modify each other's thinking. Board members are to be seen at trade union meetings; social actionists—who work for needed fundamental changes in the social structure—at child welfare and case-work and publicity meetings. Members of the white and Negro races participate in a discussion of whether Richard Wright's powerful book, *Native Son*, will help or handicap the struggle of the colored people toward better opportunity in society.

The desire of nurses to broaden their social vision was evident in the fact that they could be seen at meetings of every variety. Naturally their primary inter-

est lay in the sessions on medical care programs, led by George St. J. Perrott, Dr. Gertrude Sturges, and Dr. Kingsley Roberts; on pending federal legislation for the extension of health and medical care as discussed by representatives of the consumer, the farmer, and labor; and on needed state health legislation which will lay the basis for coöperation with the provisions of national legislation in the future, by Michael M. Davis.

But when health and social meetings conflicted, nurses frequently chose the subjects on which they are less well informed but which have deep implications for them, both as professional people and citizens: housing; adequate relief programs; the status of marriage and the family in modern life; the preservation of civil liberties; the basic causes of unemployment in a modern industrial society.

SAFEGUARDING OUR DEMOCRACY

The shadow of the war hung heavily over all the sessions and formed the chief subject of discussion at several of the great evening meetings held in Grand Rapids' magnificent auditorium. Here again the most divergent viewpoints were allowed expression—in accordance with the true spirit of democracy. The thought which echoed most insistently was the necessity, in this hour of world crisis, to safeguard the practice of the essential principles of our own democracy and to intensify our efforts to build a society with economic opportunity for all as well as political freedom.

"European experience," said Grace L. Coyle in her presidential address on the opening night, "should teach us that the despair of the people is the opportunity of the dictator. If our society cannot provide the basic satisfactions of

life for its citizens, all our democratic tradition and attitudes will not hold against the rising tide of thwarted human life."

"To destroy liberty in an effort to preserve it is the height of folly," said Rabbi Silver in a stirring address which unqualifiedly supported an adequate national defense but urged that "we should not in our great concern, in our justifiable zeal and impatience, permit ourselves to resort to extra-legal and unconstitutional methods to obtain even worthy and desirable objectives."

Another speaker specified as the goal of all our efforts an economic organization that will enable citizens in a modern state to buy from one another what modern industrial organization will enable them to produce. "In defending our democracy from invasion," he warned further, "we must keep a democracy to defend."

In the Conference, as in the Biennial Nursing Convention two weeks before, the essential partnership of the laymen and the professional in all community services held a place of first importance. The part that lay citizens can play in influencing the administration of local health services was discussed at a meeting on local government and social work. Representatives of lay groups participated in a session on citizen groups as interpreters of public welfare. A board member and attorney, Raymond W. Starr of Grand Rapids, speaking at one of the sessions on methods of social action, defined such action as "one of the means to make democracy work" and suggested a plan for promoting needed social changes through state conferences of social work with contributions from agency budgets.

BOARD MEMBERS RAISE QUESTIONS

At a lively open discussion arranged by the National Committee of Volunteers in Social Work and skillfully led

by Wilmer Shields of the Association of the Junior Leagues of America, basic and searching questions emerged: Does the professional person really want the board member to be informed on the important affairs of the agency? Does the board member really want to be educated? If so, what does he want to know and how shall we discover board interests? How can his vision be broadened beyond the work of his own agency to include the needs of the community as a whole? Why is it that business men on agency boards sometimes serve for years without any appreciable modification in their social viewpoint toward the needed social changes in which they should participate? How can board education be planned in a large city where the picture is so complex?

Methods of board education were discussed. Special orientation courses and community study groups have been used with great success. However, it was agreed that education through actual participation in agency and community work, after an introductory program of preparation, is perhaps the most effective method.

Particularly interesting was an account by a Negro from Cincinnati of a project initiated by some members of his own race to prepare Negroes for board membership in community agencies, through a series of luncheon meetings which served as a vehicle for a planned educational program. Following this project, 20 out of 22 of the Negroes participating have been appointed to membership on boards of various community agencies of the city.

One of the delightful social events of the conference was the laymen's dinner in the Pantlind Hotel Ballroom at which Barclay Acheson, associate editor of *The Reader's Digest*, told an enthusiastic audience of 500 people that our democracy offers unlimited opportunities for individuals with new ideas to contribute

to social progress, unfettered by tradition.

Meetings on interpretation embraced a range of subjects all the way from agency and community programs to broad social issues. At the stimulating meeting on interpretation through "the art of writing," conducted by the Social Work Publicity Council, social workers dared to look at their own shortcomings as well as the sad futility of shortsighted "categorical relief" as reflected in *The Triumph of Willie Pond*, a novel which was recommended as required reading in every school of social work. The importance of seeing the family as a unit which is implied in this book will meet with particular understanding on the part of public health nurses—whose generalized service was referred to in more than one session as having

achieved the goal of family health toward which social work is striving.

The parallelism in administrative methods as well as goals of our two professions was evident in the closing lines of the conference Follies, the evening of fun which is always planned half way through the strenuous week. Here the members laugh at their own foibles and break the seriousness of the crowded sessions—a seriousness unusually grave this year because of the tragic state of world affairs. As the curtain falls, two cleaning women emerge to mop up after the entertainment. One asks the other whether the social workers have enjoyed the show.

"Oh, them?" retorts the first woman looking over the darkened house at the audience. "They won't know till they have a staff meetin'." P. P.



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Planning for a Rural Delivery Service

By HELENE B. BUKER, R.N.

Careful preparation before starting a home delivery service will facilitate smoothness in operation after it is established

A HOME-DELIVERY nursing service may be administered as part of the public health program of either an official or voluntary agency. Until a few years ago practically all the home-delivery nursing services were provided by voluntary agencies, but since the provisions of the Social Security Act were put into operation, official public health agencies have assumed more responsibility for protecting the health of mother and baby at time of delivery as well as during the antepartum and postpartum periods.

Before making definite plans for a home-delivery nursing service, certain things should be taken into consideration and studied:

1. The attitudes of individuals and groups whose support will be needed for the success of the program—the physicians whose active interest and cooperation are essential, the graduate nurses, the hospital authorities, the welfare workers, and the lay groups.

2. The availability of hospital facilities for complicated cases.

3. Social and economic conditions which will help determine the desirability of such a program and the groups of women to whom the service should be made available.

4. The estimated number of babies to be born at home and the proportion of these that might be expected to need home-delivery service.

5. A determination of the number of nurses that will be needed. Studies have shown that the time a nurse spends on deliveries averages from 4½ to 8 hours; (depending on the policies of organization in regard to whether the nurse comes and goes with the physician) and that one delivery nursing visit equals the time spent in eight usual public health nursing visits.*

6. Provision for meeting the cost of the service. At the present time the majority of rural home-delivery services are administered by local health departments and the costs are met by local tax funds supplemented by state and federal funds, grants from foundations, donations from local clubs and other organizations, and fees from patients. Fees from patients are a comparatively small item in some places and are not collected at all in many others.

After these first hurdles are cleared and a decision is made to provide home-delivery service, there are other things to be done before the service is actually begun. Careful preparation before establishing the service makes for smoothness when it starts to operate.

PLANS TO BE MADE IN ADVANCE

Plans should be made for such things as the following:

1. Adequate nursing supervision.
2. A sufficient number of qualified staff nurses. Plans for the preparation of the staff by means of courses, conferences, and demonstrations may be necessary.
3. Written policies, procedures, and standing orders approved by the local medical groups.
4. Equipment and supplies.
5. Arrangements for receiving and distributing calls twenty-four hours a day and seven days a week.
6. Records and reports of services rendered.
7. The best method of fitting the delivery service into the program.

In some places the delivery service is a so-called specialized service. One or more nurses are assigned to assist with deliveries only; or nurses are assigned to render all services during the maternity cycle, while the rest of the staff nurses render all except maternity services. One of these plans is sometimes used during the experimental stages of a program as it is possibly less difficult

*Miller, Anna J.

to administer than other plans; but such a plan provides less continuity of service for the family, and fails to promote the interest and skills of the entire nursing staff in the maternal and infant nursing service.

One county which started a maternity program on a specialized basis changed to a generalized program after three and a half years, because it was believed that the specialized service had deprived both the county nurse and the maternity nurses of giving complete family health service and that duplication of visits had been unavoidable.

It has been repeatedly demonstrated that the most efficient and economical method of rendering public health nursing service is by means of a generalized program of family health service. It seems probable that delivery service is no exception. In the generalized service all the staff nurses participate in the delivery service as in all other services. The added time necessary and the irregularity of demands as to time have to be carefully considered and planned for.

ADMINISTRATIVE PROBLEMS

In the smaller areas the nurses usually work from one center and can alternate in being on call nights, Sundays, and holidays. In districts where there is a heavy delivery service, a nurse on call during the day sometimes works in the office while waiting; but more often she works in her own district, arranging her work so she can be reached by telephone or so that she can call the office at regular intervals.

In some of the larger areas or counties the nursing service is decentralized. In one district of two counties, three centers are arranged with three nurses in each. The nurses rotate for delivery calls in their own centers.

In another county, each nurse lives in

her own district and is responsible for the delivery calls in that district. She is not expected to be on call in off hours unless a delivery is pending; in this case, when she is away from home or from the office she notifies the patient's physician where she can be reached. Relief is arranged as necessary from nearby districts. This arrangement probably would be unsatisfactory in districts where nursing service was to be provided for a large number of patients or where the nurse carried a large population load. In the county cited, the nurses serve a population of 4000 to 5000.

In order to provide for a maximum number of deliveries, some agencies employ on a case basis graduate, registered nurses who are qualified and interested in participating in a home-delivery service. These nurses are often private duty nurses or sometimes married nurses who are glad to assist with an occasional delivery. This plan is considered economical and efficient although the nurses are not always as easily secured as might be thought. Adequate supervision should be provided for these nurses and they should understand the agency's policies and procedures and their responsibility for rendering a high quality of service.

Various plans for providing home-delivery services in rural communities are being tried. In a constantly increasing number of places, mothers are receiving skilled nursing care in their homes at the time of delivery, and this phase of the maternity cycle is now beginning to receive some of the attention which it deserves.

Presented before the N.O.P.H.N. Round Table on Rural Home Delivery Service, Biennial Convention, Philadelphia, Pa., May 13, 1940. Other papers from this Round Table will be published in subsequent issues.

Information Please

By LOUISE HOPWOOD

Part IV

Data on student affiliation for undergraduate and graduate students in nonofficial and official agencies are summarized here

THIS IS the final report to be published, based on the answers to the 1938 Yearly Review questionnaire, which is sent to representative public health nursing agencies all over the United States. It will soon be time to start the reports for 1939 which are being tabulated now. The N.O.P.H.N. is always glad to share these findings with those of you who respond so generously to our questionnaires, and we have a wealth of more detailed material available on request.

Of the 594 agencies which replied to the questionnaire, only 419 were asked questions about student affiliation—225 nonofficial agencies and 194 official agencies.

Undergraduate students in nonofficial agencies

Of the 225 nonofficial agencies, 67 reported having undergraduate students. The smaller organizations of course accepted less students during the year than the larger ones. Few of the small organizations have even one supervisor, since the director serves in this capacity.

Some organizations reported less than two weeks as their period of affiliation. It was decided that for the purpose of this tabulation, such organizations would be omitted since they really offer opportunities for observation rather than a true affiliation. The smaller organizations were more apt to

report shorter affiliation periods than the larger organizations.

Of the 67 agencies, only 14 reported that they received remuneration for the students. In other words, according to this sample, less than one quarter of the nonofficial agencies receive remuneration for undergraduate affiliations.

The total number of schools of nursing sending students to the 67 agencies was 174.

The reports showed wide variation as to the number of schools of nursing from which an agency received students. Two agencies stated that they accepted students from 12 and 10 schools of nursing respectively during the year, but 26 agencies accepted students from only one school.

Graduate students in nonofficial agencies

Only 36 of the 225 nonofficial agencies stated that they were receiving graduate students. The highest number of graduate students sent to any agency during the year was 108, whereas 2 agencies stated that they had received more than 150 undergraduate students during the year.

The period of affiliation varied more widely for the graduate students than for the undergraduate students. The two-months' period of affiliation was much more frequent for undergraduate students. None of the undergraduate students stayed more than three months, but 7 agencies reported that the graduate students stayed 4 months or longer. The longest period of affiliation noted for graduate students was 9 months.

This agency was connected with a university which gives field work on a part-time basis over the period of the full academic year.

Regarding remuneration to agencies, sixty-one percent of them reported that they were paid for graduate students and only twenty-one percent that they were paid for undergraduates.

Of course the number of universities sending students to an agency was fewer than the number of schools of nursing. No agency reported that they had students from more than 2 universities in 1938. Five agencies reported that they had had students from 2 universities each, and 27 reported students from one university each. Four agencies did not reply to this question.

Undergraduate students in official agencies

Only 19 of the 194 health department nursing services reported undergraduate students in 1938. The actual number of students per affiliation was also much lower than in nonofficial agencies.

The period of affiliation varied far more in the official agencies than in the nonofficial. Only 5 agencies of the 19 reported the recommended two-months' period.

It is worth noting that three official agencies reported they had received remuneration for undergraduate affiliations.

Only 2 of the 19 agencies reported that they had had students from more than 4 schools of nursing in 1938.

Graduate students in official agencies

More official agencies reported affiliation for graduate students than for undergraduate, the reverse of the findings for nonofficial agencies. There were 34 official agencies reporting graduate student affiliation. The number of graduate students per agency was lower in the official agencies than in the nonofficial agencies.

The periods of affiliation varied widely for graduate students in the official as well as in the nonofficial agencies. Only 12 agencies of the 34 stated that the accepted two-months' period was in practice. Fourteen stated that the graduate students stayed less than 2 months and 6 that they stayed 3 months or longer.

Payment for graduate students in these official agencies was more usual than payment for undergraduate students. Seventeen of the 34 agencies reported that they received remuneration for the graduate students.

Additional information about student affiliation in addition to that summarized here is available from these questionnaires. The names of the schools of nursing were asked for and also the names of the colleges or universities. The exact amount received for student affiliation work was also requested. The variations in these sums were wide, one organization reporting that it received as much as \$3500 for its undergraduate and graduate student affiliation services. This is an official agency coöperating with a school of nursing which is being assisted by a foundation.

COMMENT

In this fourth edition of "Information Please," the situation with regard to student affiliations is summarized. Several points are clear at once and answer some of the questions administrators are asking. There is great

variation in practice and some evidence that we have quite a way to go before the agencies build the student program in accordance with the recommendations of the N.O.P.H.N. Education Committee. It is desirable, for instance,

to offer the graduate student more than two months of experience. It is important that the undergraduate student have an affiliation in a service which includes a well supervised program of general bedside care. It is important to distinguish between what is purely observation for the student and a true affiliation in which she is responsible for a part of the work of the agency. It is wise to keep the length of the affiliation for the graduate student flexible to meet her varying needs and not to duplicate past acceptable experience of the student. Many administrators will be interested to see that official agencies can accept remuneration for the educational experience they offer students.

In all the problem of student affiliation the N.O.P.H.N. is interested in three aspects—the standards of the school of nursing or university seeking affiliation, the standards of the agency offering it, and the content of that educational experience. The related question of the alternative for the undergraduate student who cannot complete her whole approach to community health—an approach and awareness which we hope have been stressed throughout the school of nursing curriculum—by an affiliation with a public health nursing agency, is also the subject of committee consideration in cooperation with the National League of Nursing Education.

D.D.



NURSE PLACEMENT SERVICE



announces the following placements from among appointments made in

the various fields of public health nursing. As is our custom, consent to publish these has been secured in each case from both nurse and employer.

*Jeanette H. Bradley, Supervisor, Visiting Nurse Association, Bridgeport, Conn.

*Lyma Geiger, School Nurse, Forest Park Public Schools, Forest Park, Ill.

*Mrs. Isabel C. White, Sabine Parish School Nurse and Home Hygiene Instructor, American Red Cross, Many, La.

*Mrs. Berenice C. Gardner, Staff Nurse, Alger-Schoolcraft Health Department, Manistique, Mich.

Laura Weyrick, Staff Nurse, Houghton-Keweenaw District Health Department, Houghton, Mich.

*Mrs. Marion Chalmers, Staff Nurse, Visiting Nurse Association, Los Angeles, Calif.

*Lucile Johnson, Camp Nurse, Camp

Kechuwa, Marquette County, Mich.

Mrs. Katherine Johnson, Camp Nurse, Burr Oaks Camp, Mukwonago, Wis.

Genevieve Lipp, Camp Nurse, Camp Fire Girls, South Haven, Mich.

Elizabeth Hoover, Camp Nurse, Girl Scout Camp, Flint, Mich.

The most pressing demands for public health nurses at the moment are from the one-nurse services in small communities or rural areas throughout the country. Also, there is a noticeable increase in calls for teachers of public health nursing in the basic curriculum, usually with supervisory responsibilities in the outpatient department. On the whole the private agency requests continue to keep pace with those from official agencies. A few college nurse opportunities, providing some opportunity for study with tuition as remuneration, are going begging.

ANNA L. TITTMAN, R.N.

Executive Director.

*The N.O.P.H.N. files show that this nurse is a 1940 member.

News from the S.O.P.H.N.'s

IN REVIEWING old records on the early development of the Minnesota State Organization for Public Health Nursing, one finds that through the interest and vision of a small group of nurses, a Public Health Nurses' Section was formed in the Minnesota State Nurses' Association* in 1921. The Section was active, but it did not provide for lay membership, which is an essential accompaniment of nurse membership in the promotion of public health nursing. After careful study by a committee of the advantages to be derived from having a separate state branch of the N.O.P.H.N. in which lay people could become members, it was recommended to the State Nurses' Association* that the section be dissolved and a state branch organized. A lively debate took place at a meeting on the question: Resolved, that it is advisable to organize a separate State Organization for Public Health Nursing. The affirmative point of view was represented by two public health nurses and Dr. Richard Olding Beard.** The negative was represented by three members of the State Nurses' Association. The decision in favor of the affirmative resulted in the creation of the S.O.P.H.N. in April 1923.

The S.O.P.H.N., although young in years, has occupied a prominent place, along with the other two state nursing organizations, in the development of all phases of nursing. The presidents of the Minnesota State Nurses' Association and the State League of Nursing Education are members of the board of directors of the S.O.P.H.N., and the president of the S.O.P.H.N. is a member of the S.N.A. board.

*Formerly called the Minnesota State Registered Nurses' Association.

**Dr. Beard, who is now dead, was active in the early development of nursing education and public health nursing in Minnesota.

The objectives of the S.O.P.H.N., according to the constitution, are:

1. Stimulation of responsibility for the health of the state by furthering the establishment and extension of public health nursing and the education of nurses in public health.
2. Upholding the accepted standards and techniques in public health nursing.
3. Facilitating efficient coöperation between nurses and health officers, physicians, dentists, board and nursing committees, and other agencies interested in public health.

The Organization serves as the interpretive link between its members and the National Organization for Public Health Nursing. The S.O.P.H.N. sends a delegate to the Biennial Convention and also to the meeting of the Council of Branches of the National.

Through its Lay Section, the Organization has sponsored legislation relating to public health nursing. It is through the efforts of the State Organization that the law providing for the employment and supervision of public health nurses by official agencies is in effect. The S.O.P.H.N. has a representative on the Certification Committee that passes on the qualifications of nurses before they can become certified public health nurses in the state.

The Legislative Committee is now carrying on a program to create public opinion in support of a bill to be introduced in the next legislative session providing state aid to county nursing services. To this end it has been in contact with representative organizations such as the League of Women Voters, State American Legion Auxiliary, and the Federation of Women's Clubs.

The Education Committee has carried on an extensive educational program for its nurse and lay members and allied organizations interested in the public's health. The committee's project for a number of years was to sponsor annually

a series of twelve lectures on various phases of public health to senior students in schools of nursing. This year the demonstration seemed to have fulfilled its original purpose and has been taken over by the Extension Division of the University of Minnesota.

WORKING WITH OTHER GROUPS

This year, through a joint coöperative arrangement, the State League of Nursing Education is working with the Education Committee of the S.O.P.H.N. to formulate plans for the preparation of prospective instructors, in anticipation of introducing public health into schools of nursing.

The Organization maintains an active interest in the program of the State Conference of Social Work through organizational membership which entitles it to six voting delegates at the State Conference.

The S.O.P.H.N. supports the plan for a joint committee on community nursing with membership from the three nursing organizations in the state.

The chairman of the Lay Section is a member of the lay advisory council of the State Nurses' Association.

The relationship with the medical society is strengthened through a committee on public health nursing appointed by the president of the State Medical Society. The chairman of this committee is an *ex officio* member of the S.O.P.H.N. board of directors.

This committee has worked closely with the Division of Public Health Nursing in the Minnesota State Department of Health in helping to set up policies relating to public health nursing in general. Through the guidance of this com-

mittee, suggested standing orders for public health nursing services were formulated and assistance is given in the revision of these from time to time. The committee has offered the same assistance to the industrial nurses whenever the Industrial Nursing Section is ready to set up uniform instructions for nurses in industry.

The S.O.P.H.N., through its History Committee, has been collecting data with the aim of writing a history on public health nursing in Minnesota. A member of this committee contributes information on public health nursing to *The Minnesota Registered Nurse*.

The Organization holds two meetings a year. The annual meeting is held in the fall jointly with the State Nurses' Association and the League of Nursing Education. The three organizations plan the program together. The S.O.P.H.N. is responsible for arranging the program for one general session.

The spring meeting is held simultaneously with the annual institute for public health nursing, which is sponsored by the State Department of Health. A nurse member of the S.O.P.H.N. and the chairman of the Lay Section assist in planning the nurses' and committee members' continuation study course and the program for the institute for public health nursing. This partnership program has resulted in the stimulation of lay interest in public health nursing and is one of the best assurances we have for increasing both lay and nurse membership in the N.O.P.H.N. and S.O.P.H.N.

ANN S. NYQUIST, R.N.

President, Minnesota State
Organization for Public Health Nursing

It is the custom of the Maryland State Organization for Public Health Nursing to present their retiring president with the N.O.P.H.N. pin. The officers of the S.O.P.H.N. and chairmen of the committees gave a surprise dinner on May 7 for Bessie Lee Maston, retiring president for 1939, and gave her the pin as a token of appreciation.

Your N.O.P.H.N.

SINCE "health for three-thirds of a nation" has become a national slogan in this country, there has been increased interest in the health status of industrial workers who tend to be a part of that economically lower third which has the greatest health needs but in the past has received the least health and medical service.

Compensation for occupational diseases and accidents suffered by the industrial worker has been to a greater or less extent provided for through legislation in most states. These disabilities, however, do not form the major health problems of the industrial worker. Instead, it has been found that nonindustrial illnesses and accidents—the same colds, digestive upsets, and accidents in the home or on the highway suffered by the world in general—cause most of the workers' absence from work due to illness. Hence, a good industrial hygiene program now includes, besides first-aid treatment, many of the activities for prevention of illness and promotion of health to be found in any general public health program.

For this reason the public health nurse, who has long been recognized as having an essential role in almost every part of the community health program, obviously has an important part to play in industrial health work as well.

Though the first industrial nurse was appointed as long ago as 1895, almost half a century later there were only 2800 industrial nurses in the whole country, according to the last U. S. Public Health Service count made in 1939.

"To stimulate interest in the special problems of the industrial nurse and to provide a forum for the discussion of such problems,"* the Industrial Nursing

Section of the National Organization for Public Health Nursing was formed in 1920. Up to the present time, it has not become a strong section numerically but from the beginning it has had some devoted leaders both among nurses and people outside the nursing profession. From the beginning also it has had the support of the N.O.P.H.N. Board of Directors as a whole.

Now, with awakened interest on the part of public officials, employers, and employees alike in the problems of industrial health, opportunities of the Industrial Nursing Section to assist with sound promotion of industrial nursing are greatly increased.

The activities of the Section follow the same lines as do functions of the N.O.P.H.N. as a whole. In brief, they fall under three main headings:**

1. The setting and promotion of standards in industrial nursing, including educational phases of the program, content, practice, and vocational counseling.
2. The promotion of understanding and interest among industrial executives, public health officials, safety engineers, personnel managers, industrial physicians, and just plain citizens with regard to the role nurses can play in the industrial health and industrial relations programs.

3. The promotion of relationships with other national groups which are especially interested in industrial health.

The Industrial Nursing Section during recent years has completed:

1. A statement of functions of the industrial nurse.
2. A statement of desirable quali-

* Bylaws N.O.P.H.N. Industrial Nursing Section.

** Gardner, Mary S., "Report of the Functions Committee." PUBLIC HEALTH NURSING, April 1938, p. 240.

cations of nurses appointed to public health nursing positions in industry. This has been approved both by the N.O.P.H.N. and by the American Public Health Association.

3. Suggestions for preparation of the industrial nurse. These have been accepted by the Education Committee of the N.O.P.H.N. and distributed to directors of university programs of study in public health nursing. Increasingly, special application of general principles to industrial conditions is made in connection with many of the courses given in these programs of study, and in several colleges evening courses and institutes have been offered to industrial nurses already in the field.

The Section has used various methods to promote understanding and good relationships with other national groups and with individuals other than nurses who are concerned with industrial health. Its executive board includes five people who are not nurses. At present they are an employer, the wife of an employer, an industrial physician, an industrial engineer, and the managing director of the National Safety Council.

Also, contacts have been made recently with each of the following national organizations:

The Division of Industrial Hygiene of the United States Public Health Service

The National Association of Manufacturers, through its Committee on Healthful Working Conditions

The Industrial Hygiene Section of the American Public Health Association

The Committee on Industrial Medicine and Traumatic Surgery of the American College of Surgeons

The Council of Industrial Health of the American Medical Association

The American Industrial Hygiene Association.

The National Safety Council

The industrial hygiene divisions of state health departments and industrial commissions of various states

All these groups have been helpful, and to some at least the Industrial Nurs-

ing Section has in turn been able to render service.

The development of health work in industry is especially needed in smaller plants employing fewer than 500 people. Over 60 percent of the people in the industrial and mechanical trades are in these smaller establishments* and they number some 98 percent of the total industrial firms of the country.** It is in these smaller plants that the well qualified industrial nurse, who is often the only full-time health worker employed, may become a key person.

The Section has three special projects for the immediate future. The first of these is to find out a great deal more than is known at present about industrial nursing as it is now carried on, in order to give help and set standards more wisely. To promote this objective, a study outline is being compiled which it is hoped local groups of industrial nurses and others will use in finding out current practice in their own communities.

Second, it is the desire of the section to stimulate state nursing organizations to provide vocational guidance to nurses interested in industrial nursing.

The third project is to secure as a member of the N.O.P.H.N. staff and full-time secretary for the Industrial Nursing Section, a nurse who has had experience in industry. So far money has not been available for this project. But the members believe it is only with this kind of consultant service that the Section can do its full share in meeting the present challenge to the nursing profession to increase its service to industry both in amount and quality.

RUTH HOULTON, R.N.
Associate Director

* Houlton, Ruth. "Nursing Service for the Small Plant." *PUBLIC HEALTH NURSING*, September 1939, p. 515.

**Prendergast, John J. "Industrial Medical Department Organization." *American Journal of Public Health*, June 1939, p. 641.

NOTES *from the* NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING



MISS CONNOR APPOINTED

The N.O.P.H.N. announces the appointment of Mary C. Connor as assistant director in charge of educational activities to succeed Virginia A. Jones. Miss Connor will join the staff in the early fall.

Miss Connor comes to us from a position with the Montgomery County Health Department, Rockville, Maryland. She is a graduate of Hunter College and Lenox Hill Hospital School of Nursing, New York City, and her public health nursing experience has included, besides completion of work for her M.A. degree at Teachers College, Columbia University, rural and urban service in official and non-official agencies, supervision, the direction of the program of study at the Catholic University of America, Washington, D.C., and serving as educational director in the Instructive Visiting Nurse Society, Washington, D.C.

HONOR ROLL

Are you the *one* nurse who is keeping your agency off the Honor Roll? If you're holding up the 100 percent enrollment of your staff, won't you send your membership dues today and see

to it that your agency is listed on the Roll of Honor?

Don't forget that any nursing staff whether of school, industry, health department, visiting nurse association, or any other organization is eligible. And one-nurse services too! Be sure to notify us as soon as your staff is 100 percent enrolled. That is the only way we have of knowing when to send your Honor Roll Certificate and to add the name of your agency to the growing list of Honor Roll Agencies.

ALABAMA

Fayette County Health Department,
Fayette
Elmore County Health Department,
Wetumpka

ARKANSAS

Conway County Health Department,
Morrilton

CALIFORNIA

California Tuberculosis Association, San
Francisco
Metropolitan Life Insurance Nursing
Service, Stockton

COLORADO

*Weld County Health Department,
Greeley

CONNECTICUT

New Milford Visiting Nurse Association,
Inc., New Milford
Enfield Visiting Nurse Association,
Thompsonville

DISTRICT OF COLUMBIA

*American Red Cross National Head-
quarters, Washington

FLORIDA

Metropolitan Life Insurance Nursing
Service, St. Petersburg

GEORGIA

*Metropolitan Life Insurance Nursing
Service, Atlanta

ILLINOIS

*Metropolitan Life Insurance Nursing
Service, Alton
Metropolitan Life Insurance Nursing
Service, Centralia

*Visiting Nurse Association, Evanston
Geneseo School Nursing, Geneseo
Springfield Health Department, Spring-
field.

*Agencies which have been on the Honor Roll
for five years or more.

INDIANA

- *Evansville Public Health Nursing Association, Evansville
- District Health Department No. 3, Indiana State Board of Health, New Albany

IOWA

- Dubuque School Health Department, Dubuque
- *Community Nursing Service, Marshalltown

KANSAS

- Eureka Board of Education, Eureka
- *Visiting Nurse Association, Kansas City

KENTUCKY

- Nicolas County Board of Health, Carlisle
- Visiting Nurse Association, Louisville

MAINE

- Augusta Tuberculosis Prevention Service, Augusta

MASSACHUSETTS

- *Canton Hospital and Nursing Association, Canton
- Hanover Visiting Nurse Association, Inc., Hanover
- *Visiting Nurse Association, Pittsfield Board of Health, West Springfield

MICHIGAN

- Metropolitan Life Insurance Nursing Service, Battle Creek
- Bureau of Public Health Nursing, Department of Health, Lansing
- Monroe County Chapter, American Red Cross

MISSOURI

- Pemiscot County Unit, State Board of Health of Missouri, Caruthersville
- St. Louis County Health Department, Clayton
- Missouri Public Health District No. 5, Salem

NEW HAMPSHIRE

- Union School District, Keene

NEW JERSEY

- *Visiting Nurse Association of the Oranges and Maplewood, Orange
- Bureau Local Health Administration, State Department of Health, Trenton

NEW YORK

- Metropolitan Life Insurance Nursing Service, Hudson

NORTH CAROLINA

- Gaston County Health Department, Gastonia
- Northampton County Health Department, Jackson

OHIO

- Metropolitan Life Insurance Nursing Service, New Philadelphia

OREGON

- Lane County Public Health Department, Eugene
- *Umatilla County Health Unit, Pendleton

PENNSYLVANIA

- Metropolitan Life Insurance Nursing Service, Pottstown
- Community Health Society of Central Delaware County, Swarthmore

RHODE ISLAND

- *North Providence District Nursing and Tuberculosis Association, Centerdale
- *Metropolitan Life Insurance Nursing Service, Newport
- Rhode Island State Health Department, Providence
- Warwick Health Department, Warwick

TENNESSEE

- *Rutherford County Health Department, Murfreesboro

UTAH

- *Salt Lake Visiting Nurse Association, Salt Lake City
- *Metropolitan Life Insurance Nursing Service, Salt Lake City

WASHINGTON

- Metropolitan Life Insurance Nursing Service, Bremerton
- Metropolitan Life Insurance Nursing Service, Tacoma
- Clark County-City Health Department, Vancouver

WISCONSIN

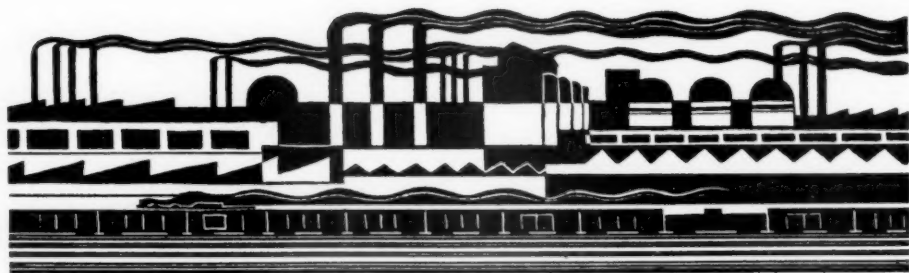
- Neenah Health Department, Neenah

ALASKA

- United States Department of the Interior, Chitina

The N.O.P.H.N. is planning a group conference on orthopedic nursing on October 6 and 7, just before the American Public Health Association convention in Detroit, Michigan. The subject of the conference will be "Content and Method of Staff Education in Orthopedic Nursing," and the leader will be Jessie L. Stevenson, assistant director of the N.O.P.H.N.

Registration is open to 30 supervisors or nurses responsible for orthopedic programs. There will be no registration fee since expenses will be paid by the National Foundation for Infantile Paralysis which finances the N.O.P.H.N. orthopedic nursing project. Reservations must be made by September 15.



THE INDUSTRIAL NURSE IN THE EUROPEAN WAR

THE ROLE of the industrial nurse in protecting the health of workers in a nation at war is succinctly described in an editorial in *Nursing Times*, the Journal of the Royal College of Nursing in London, England, April 20, 1940. The discussion is reprinted in part here:

SINCE INDUSTRY carries . . . added risks, there is need also for added care. The importance of the fact needs no stressing now. The output of our munition, aeroplane, and other factories is vital to the outcome of the struggle the nation has to face, and the output of our other factories, making foods for our consumption and goods for export to supply the financial sinews of war, is of almost equal importance.

Who can supply this additional care better than the doctor and the nurse? "Wherever possible a trained nurse should be on regular duty" in every munition factory. This statement comes from the report of the committee which considered the health of the munition worker during the Great War under the chairmanship of Sir George Newman. There were no nurses on the committee to influence those who made the report. Their opinion was the result of careful and prolonged investigation.

Why did they want a nurse regularly on the spot? Partly for the treatment of accidents. . . . [But] the nurse who can merely treat accidents well is a failure in industry. The industrial nurse who is a success is the one to whom the employees come—the one the employees

seek out to ask for advice before the accidents ever happen and who can inspire them with an enthusiasm for maintaining their health and efficiency.

Her interest in the well-being of the employees will be her first consideration. Her actual practical nursing will consist mainly of dressing of minor injuries and attending to minor ailments. She might call it dull work if she had not the vision to see and seize her opportunities to teach and guide those with whom she comes into contact in the ways of healthy living.

She can also assist the workers by the records she keeps. If advances are to be made and lessons learned from the mistakes of the past, there must be information from which deductions can be made. When inquiries are desirable, will it be possible to say how many accidents and how much sickness occurred; whether it occurred at any particular time of the year or hour of the day, perhaps towards the end of a shift which was too long, or during overtime or night work? It has been possible to prove from statistics of output that an undue lengthening of hours resulted in a diminished output of work as a result of loss of efficiency. Were there also records

to show an increased rate of accidents and sickness as a result of too long hours?

"We manufacturers are always perfecting our dead machines, but of our living machines we are taking no care," quoted Sir George Newman. This is not always true but it often is. The best opinions of the time demanded a nurse in every munition factory towards the end of the last war. Shall we benefit

from all the time and thought given to the problem then? The College has tried to prepare the ground by arranging an intensive, reduced course of training in industrial nursing at headquarters. One has already been completed and another will be arranged if there is the demand. We hope there will be the demand, for the workers of our vital industries need the industrial nurse to advise them and watch over their health.

SILVER JUBILEE OF THE NEW ENGLAND ASSOCIATION

THE NEW ENGLAND Industrial Nurses' Association celebrated its twenty-fifth anniversary meeting at The Parker House in Boston, May 25 and 26, 1940, with 165 members and guests attending.

The Silver Jubilee dinner was held following the general business sessions. The president, Catherine R. Dempsey, presided and Dr. Richard McCoart, medical director of the Universal Wind-ing Company, Providence, Rhode Island, was toastmaster. The commissioner of public health of Boston, Dr. Paul J. Jakmauh, welcomed the guests, and Mrs. Anna M. Stabler of Los Angeles, California, honorary president, brought greetings.

Mrs. Stabler has the honor of being the first nurse to take a course in public health nursing with the industrial field in view. In 1915, she with a group of 12 nurses started the Boston Industrial Nurses' Club.

Industry was humming and nurses were needed in the busy plants to help conserve man power. Employers, public health organizations, and leaders in the industrial and health field vied with each other in giving the club a boost. One of the club's earliest purchases was a mimeograph machine described as the most mule-like thing ever seen off four feet. Its balking and stiff joints needed constant lubrication. But the prowess of Evelyn Coolidge, a past president of

the club and a graduate in safety engineering, always succeeded in coaxing it to go, by fits and starts until complete reports of each club meeting were in the hands of every member as scheduled.

Membership in the club increased steadily. And the Boston Industrial Nurses' Club of yesterday became the Massachusetts Industrial Nurses' Club and is the New England Industrial Nurses' Association of today.

Addresses at the dinner were as follows:

"The Use of Masks in Preventing the Spread of Infections"—Professor Philip Drinker, Department of Industrial Hygiene, Harvard School of Public Health, Boston, Massachusetts.

"Industrial Hernias"—Dr. Herbert H. Howard, Boston, Massachusetts.

"Human Understanding—A Prerequisite of Industrial Nursing"—John H. McManus, vice-president, John P. Squire and Company, Cambridge, Massachusetts.

Major David Weden brought a personal message from Governor Saltonstall of Massachusetts. Dorothy Deming, general director of the National Organization for Public Health Nursing, Mrs. John Seaman, president of the Massachusetts Organization for Public Health Nursing, and Margaret Boyle, president of the Massachusetts State Nurses' Association, all brought good wishes from the groups they represented.

Guests of the Association were: Belle

Carver, president of the New York Industrial Nurses' Club; Elizabeth Sennewald, president of the New Jersey Industrial Nurses' Club; and Mrs. Kathleen K. Dempsey, president of the Philadelphia Industrial Nurses' Club.

The Massachusetts Safety Council was represented by Ralph Pendleton, assistant director. Industrial and medical groups were represented by physicians, personnel directors, and industrial relations managers from leading industries in Massachusetts.

On May 26, a breakfast meeting was

held at The Twentieth Century Club, with Dorothy Deming as the guest speaker, followed by an informal round table discussion.

Winifred Hardiman, industrial nurse of The Terry Steam Turbine Company of Hartford, Connecticut, is the newly elected president of the Association, and Catherine Dempsey, the retiring president, was elected to membership on the Board of Directors.

CATHERINE R. DEMPSEY, R.N.

President, The New England Industrial Nurses' Association

INSTITUTE IN CLEVELAND

AN INSTITUTE for industrial nurses was held by Western Reserve University School of Nursing in Cleveland, Ohio, April 27, 1940, at the request of the industrial nurses and others interested in this field. Notices were sent to the industrial nurses of Ohio and West Virginia and to public health nursing groups and schools of nursing in Cleveland.

The nursing program in an industry where there are comparatively few accidents was described by Mrs. Eleanor Williamson of the Fred Sanders Confectioners, Detroit, Michigan, at the afternoon meeting. She emphasized the need for health education and described various educational methods such as posters, bulletins, and personal contact with the employers as they visit the dispensary. A discussion period followed her talk.

A clever imaginary conversation of an industrial nurse with a plant watchman by Mrs. Marion Fluent was the feature of the dinner meeting. This dialogue brought out many points pertaining to health education and the preventive aspects of industrial nursing. Mrs. Fluent is director of the University Public

Health Nursing District in Cleveland.

Industrial nursing was discussed at the evening meeting by Dr. Carey P. McCord, director of the Industrial Health Conservancy Laboratories of Detroit. Dr. McCord has an understanding of the problems of the industrial nurse derived from long experience as an industrial physician and from teaching classes of public health nurses who are graduate students at Wayne University. He stressed the importance of considering human needs in industrial nursing and pointed the way to a much wider scope for their work. The necessity for nurses to get into the plant and become aware of conditions under which the men work was emphasized. Accidents and lost time may be greatly reduced, Dr. McCord believes, by a nurse who is interested in the workers as persons, who knows and helps solve their problems, and who knows the conditions under which they work.

An interested group of about sixty nurses—of whom thirty-six were industrial nurses—attended the meetings.

HELEN M. LEHMANN, R.N.

*Western Reserve University,
Cleveland, Ohio*



EDITED BY ANNA C. GRING

SOCIAL CASE WORK IN PRACTICE

By Florence Hollis. 313 pp. The Family Welfare Association of America, 122 East 22 Street, New York, 1939. \$2.50.

This book presents a series of six case studies selected from records of the Cleveland Associated Charities. The histories chosen were successful cases which should provide valuable teaching material. The clients came from the same general economic and cultural level; but varying environmental pressures and internal stresses led to the necessity for social case work.

Each case study is interspersed with analysis by the author, and followed by a short summary of the situation and treatment. The progress made by the client, the emotional tone of the worker, and the flexibility of therapy applied are portrayed with clarity in each study.

The author is a keen analyst of the causes which produced the clients' behavior, the reaction of the worker, the treatment she offered. Such generous explanation of details leads one to wonder whether the author by her interpretation is not the best social worker in the book.

The book should be of interest to public health nurses for at least two reasons: to learn (1) the techniques used by social workers (2) the importance of permitting the free flow of thought of the client.

MARGARET BLEE, R.N.
Berkeley, California

FETAL AND NEONATAL DEATH

By Edith L. Potter, M.D., and Fred L. Adair, M.D. 207 pp. The University of Chicago Press, Chicago, 1940. \$1.50.

According to the authors, this brief volume of some two hundred pages presents a survey of the incidence, etiology, and anatomic manifestations of the conditions producing death of the fetus *in utero* and the infant in the early days of life. Some of the reasons for such deaths are shown and the material is presented so that it may serve as a basis for further investigation.

The first chapter sets forth a statistical analysis of the incidence and causes of deaths occurring before or during birth or in the first month of life. Many such deaths cannot be prevented by means now known, but the authors estimate that fully two fifths of the deaths might be avoided if knowledge now possessed were applied. Causes which might lend themselves to an attack for reduction are prematurity, birth injury, anoxemia, infection, and unfavorable environmental conditions immediately following birth.

The next section presents very briefly the incomparable story of the development of the fertilized ovum into a complex structure of intricate function—that is, the growth and development of the fetus. Here are shown tables of growth in weight and height in relation to fetal age; timetables showing when ossification centers appear; criteria for classifi-

cation as to period of development; and charts showing organ weight in relation to body weight. There is also a brief description of the normal and pathological appearance of the principal organs of the body to serve as a basis for comparison between the two.

The authors point out that it is extremely difficult to compare studies or evaluate different factors as causes of death without more adequate postmortem examination than is at present obtainable. The third chapter aptly deals with the techniques for making such examinations and lists procedures to be followed. A discussion of the major factors causing or contributory to death follows. The final chapter deals with the special pathology of the skin, the respiratory, circulatory, gastro-intestinal, and nervous systems, the placenta, and the amniotic sac found upon necropsy to be causative factors in fetal or neonatal deaths.

The volume contains much descriptive material of vital interest to doctors, nurses, and students, and fulfills a long-felt need in our literature concerned with the problem confronting those engaged in public health and medical practice—the problem of reducing an almost stationary incidence of fetal and neonatal mortality.

ESTELLA FORD WARNER, M.D.
Albuquerque, New Mexico

THE GRADUATE NURSE IN THE HOME

By Mary Louise Habel and Hazel Doris Milton.
290 pp. J. B. Lippincott Company, Philadelphia,
1939. \$2.50.

Written for the senior student nurse or the graduate nurse who is presumably thoroughly familiar with basic principles of nursing care and standardized procedures, this book gives a wealth of practical suggestions which may be applied in the home. The simplicity of

improvisations described should make them useful in almost any home situation. For the graduate nurse to whom certain procedures may have become hazy, the emphasis placed on specific technique should offer a challenge to review essential principles. In a few instances the interpretation of the nurse's function is questionable. For example, a description of how to administer an anesthetic during labor in a physician's absence would seem a dangerous subject.

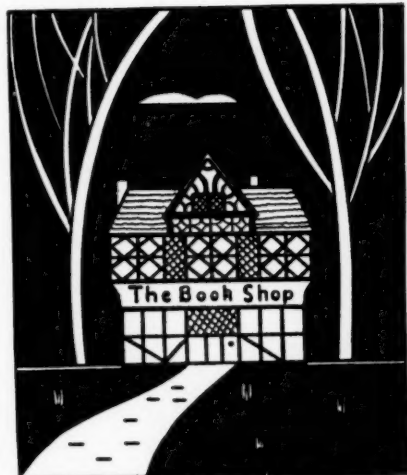
The convenient arrangement of the material makes the book a valuable reference. In each of the five phases of nursing discussed, suggested methods of adapting principles involved and related teaching opportunities are included. The book should make a real contribution toward improved care of the sick.

DOROTHY RUSBY, R.N.
New York, New York

MATERIAL ON DIABETES

The Metropolitan Life Insurance Company has initiated an educational program to inform the public regarding diabetes. Its little blue pamphlet on *Diabetes*, authoritative and written in popular style, will be of special value to the nurse for use in education of patients and families. A set of six exhibit charts on the prevention, treatment, and prognosis of diabetes is available from the Company without charge for use at meetings of nursing groups. A window exhibit, "Are you in the diabetes line-up?" is suitable for use in clinics and classes. This is an easel-back display card, 21½ x 29 inches, in color. These materials will be extremely helpful in staff education and public education. They may be obtained from the Welfare Division, Metropolitan Life Insurance Company, 1 Madison Avenue, New York, N.Y.

Vacation Reading



By Kate Coe, Englewood, New Jersey

We are again publishing reviews of suggested summer reading, in this issue, as our contribution to a pleasant vacation.

WILD GEESSE CALLING

By Stewart Edward White. 577pp. Doubleday Doran, New York, 1940. \$2.75.

This is an enjoyable novel of the early Alaskan pioneer. It is the story of John and Sally Murdock whose vagabonding spirit led them to Alaska—not in search of gold but to find and help conquer a new frontier. From northern Scotland came the first of the clan of Murdock who had the wanderlust that was handed down to John—the everlasting search for a place in which to take root. Sally had a bit of this in her, too, so together they led a carefree life roaming the Northwest wherever their spirit beckoned.

John's purchase of a sailboat was the beginning of their trip to Alaska. The voyage from Seattle along the coast up to Alaska is one of the most interesting and exciting descriptions read in a long time. They were to live in peace for two years before the wild cry of "gold" was heard. The surge of mad, grasping

people swept by Sally and John in their cabin while they stayed to build a home and a future of happiness. Theirs was the true pioneering spirit!

R.B.L.

WE DIDN'T ASK UTOPIA

By Harry and Rebecca Timbres. 290 pp. Prentice-Hall, Inc., New York, 1939. \$2.50.

This is perhaps the most honest and unbiased—and certainly the most intimate—picture of life in Soviet Russia that has emerged in the past few years. It consists of the day-by-day letters and journal of a young American doctor and his wife, a nurse graduated from Presbyterian Hospital in New York, who in 1936 went to one of the most primitive parts of the Soviet Union to live and work with the people, employed by the government. The story of these young Quakers and their two children answers many questions that an outsider asks himself about life among the Soviets. It is an intensely human, moving story, written without embellishment as it occurred, by people with a deep sense of social values. In these times of upheaval and anxiety it helps to give one faith and perspective on the enduring verities of life.

As Dr. C.-E. A. Winslow says in the introduction: "This picture [of the Timbres family] is of profound social significance, because it is the kind of people here made known to us who represent the hope of the world."

P. P.

CANOE COUNTRY*

By Florence Page Jaques. Illustrations by Francis Lee Jaques. 78pp. The University of Minnesota Press, Minneapolis, 1938. \$2.50.

This is the summer to explore some of the beauties of nature to be found in this country of ours. To take a canoe trip

*See page 469 for illustration from the book.

through lakes uninhabited by man and full of wild life is a vacation experience which is a delight to a true nature lover. *Canoe Country* describes such a trip. Here is Mrs. Jaques' diary of their journey which her husband has illustrated with exquisite drawings.

To one who is familiar with the Minnesota lake country it is a joy to relive former trips through the pages of this book. And one who has never paddled up a quiet stream at dawn to see a moose, or has never slept on balsam boughs under the stars will be tempted to start dreaming of such a trip.

E.K.D.

MISS SUSIE SLAGLE'S

By Augusta Tucker. 332 pp. Harper and Brothers, New York, 1939. \$2.50.

Within the covers of this book are packed the joys and the disappointments, the romance, the comedy, the tragedy, and the high hopes of a group of potential physicians, research men, and pathologists studying at the famous Johns Hopkins Hospital and Medical School. This story of the years when Kelly, Halsted, Welch, and Osler were the men of medicine is told with humor, pathos, knowledge, and understanding of hospital life.

Undoubtedly nurses, doctors, and others will read this story of doctors in the making avidly. But not less interesting is the graphic description of Baltimore's markets on Christmas Eve. The reader can taste the salty Chincoteagues, see the aisles of counters with poultry, nuts, freshly prepared horse-radish and freshly shredded coconut, cheeses of all nationalities, pies, cakes, breads—everything that a thrifty housewife might desire. Or one can hear two of Miss Susie's ex-boarders who have since developed into leaders in American medicine singing "Little Elize" after drinking generously of Hizer's eggnog on Easter morning.

Although the story centers around

Hopkins and its products, the characters without whom there could have been no story are Miss Susie Slagle, who kept a medical boarding house for 27 years, Hizer, Negro cook and man of all work, and Otto, owner of the beer-garden, which is described as an important part of the legend of Johns Hopkins.

Truly the reader is quite convinced that a good Hopkins physician is impossible without the joint efforts of Johns Hopkins plus Otto, Hizer, and Miss Susie Slagle.

A. C. G.

THE LOON FEATHER

By Iola Fuller. 419pp. Harcourt, Brace and Company, Inc., New York, 1940. \$2.50.

This simple story of the first twenty-five years in the life of an Indian girl covers the period from 1808 to 1833, which is a critical one for the Indians of the Michigan territory. Oneta, heroine of the book, is the daughter of Tecumseh and it is through her eyes that the readers see the gradual breakdown of Indian power and integrity as the Americans pushed relentlessly inland on their new continent. Although the narrative interest of the book is slight and there is almost no plot development, the picture of the disintegration of an Indian tribe makes the novel absorbing and well worth while, especially for those who are interested in this neglected chapter of the story of the United States.

In the character of Oneta one can see clearly the conflict of two civilizations. As the daughter of Tecumseh who fought with the British against the Americans in the War of 1812 in a last valiant effort to dislodge the intruder, Oneta owes a loyalty to the Indian tribes which is deep-rooted and permanent. As the stepdaughter of a French gentleman and a student at the convent of the Ursulines in Quebec, Oneta comes to understand the value of the Old World's civilization and also can recognize more clearly than can the Indians the fact that their

civilization in the New World is doomed. The resolution of this conflict gives importance and breadth of meaning to the book. This is not just another pioneer novel of the winning of the West; it is the story of the losing of the West by a people fighting against insuperable odds.

M.W.

A CASTLE IN CARINTHIA

By Johan Fabricius. 489pp. Random House, New York. \$2.75.

A Castle in Carinthia is a story of an Austrian family, covering the years from 1889 till after the World War.

George von Weygand, a middle-aged nobleman and cavalry officer in Franz Joseph's Imperial army, after the death of his wife and several lonely years spent in an officers' club in Vienna, retires to the family castle, a medieval stronghold buried in the depths of fields and forests in the province of Carinthia, near Klagenfurt.

He marries again and feels life returning to him in all its richness when his young and delicate second wife at the risk of her life gives birth to four children in rapid succession. It is with these children, their development, and what the war does to them that this story is chiefly concerned.

The eldest boy, Rudi—gentle and idealistic—in following the tradition of his father gives his life for his country, falling with his comrades in the cavalry unit in battle. Elizabeth, the second child, falls in love with the family tutor, a German, and loses him when he returns to Germany to fight and die. The head-

strong daughter, Angelique, at the eve of the war runs away from her family and marries a French violinist. And the youngest boy, Stephan, becomes a product of the war generation—bitter, cynical, and unscrupulous.

One feels the desperation and the helplessness which lay over the vanquished Germans and Austrians during the last days of the war and the ensuing peace. A breakdown of the old order, hunger, despair, and profiteering follow, as always, in the wake of war, and all the young men of the gay Vienna days lie dead.

A.B.N.

POLISH PROFILE

By Virgilia Sapieha. 319 pp. Carrick and Evans, Inc., New York, 1940. \$2.50.

This is an extraordinary story of life in rural Poland before the Nazi invasion, by the American wife of a Polish prince. It is a picture, as seen through the eyes of an American girl, of an anachronistic feudal society in which the peasants lived a submarginal existence of poverty and fatalism that made social progress under the new Polish state almost impossible. The opposition of the landowners to the breaking up and distribution of the huge estates; the reactions of Poles toward the growing power of the Nazi regime; the deep prejudices among national and racial minorities in Poland—these and many other threads interwoven in the story of the author's adjustment to her new life make the book an absorbing social document of great significance in the light of subsequent events.

P. P.



NEWS NOTES

- Public health nurses throughout the country will be saddened to learn of the death of Dr. Philip P. Jacobs, director of personnel training and publications of the National Tuberculosis Association, on June 12, after an illness of three months. Dr. Jacobs was the oldest employee in point of service of the National Tuberculosis Association, having served the organization for thirty-two years. Since 1916 he had conducted periodic institutes for the training of tuberculosis and health workers throughout the country.

- Just as we go to press comes the sad news of the death of Elizabeth Stringer. Miss Stringer, for 24 years director of the Visiting Nurse Association of Brooklyn, N. Y., had resigned her position to take effect this summer but suffered a severe attack of pneumonia in January and has been ill since that time. She died on July 12.

Miss Stringer was a charter member of the National Organization for Public Health Nursing, a board member during the years 1914-1917, and throughout the years of the N.O.P.H.N.'s existence has been a tireless worker on many committees.

- Mrs. William Kletzer of Portland, Ore., was elected president of The National Congress of Parents and Teachers at its forty-fourth annual convention in Chicago, May 7, 1940.

- The twenty-fifth National Recreation Congress will meet in Cleveland, Ohio, September 30 to October 4.

- A Women's Centennial Congress of The Women of America will be held in New York City, November 25-27. The chairman of the National Committee planning the Congress is Mrs. Carrie

Chapman Catt. The Congress will celebrate the achievements already won in behalf of the rights of women as citizens and will study the discriminations which still exist in regard to women and the responsibilities which they as citizens should carry in regard to meeting the social, economic, and political problems of our generation. The congress will be particularly interested in the cause of world peace.

- Venereal disease quackery is on the increase and constitutes one of the major obstacles to the public health control of this disease according to a recent broadcast made by officers of the U. S. Public Health Service. This trend was reported in a survey conducted by the American Social Hygiene Association in coöperation with the U. S. Public Health Service. The report of the study, by Mary S. Edwards and Paul M. Kinsie, was published in the January 1940 issue of *Venereal Disease Information* under the title, "Illegal and Unethical Practices in the Diagnosis and Treatment of Syphilis and Gonorrhea."

Personal interviews by trained investigators posing as "friends" of presumably infected persons were carried on in 1151 drug stores in 35 cities in 26 states. Sixty-two percent of the drug stores visited diagnosed the diseases and offered to sell remedies for alleged syphilis or gonorrhea, especially the latter. About half of those who sold remedies urged the inquirer to see a doctor. Only 7 percent of the entire number refused to diagnose or sell remedies.

- At the recent meeting of the National Conference of Social Work in Grand Rapids, Mich., Jane M. Hoey, director of the Bureau of Public Assistance, Social Security Board, Washington, D. C., was elected its president.

PUBLIC HEALTH NURSING

Official Organ of the National Organization for Public Health Nursing, Inc.



Children Are the Strength of the Nation

TODAY, as never before in our history, the welfare of the nation's children is its source of inner strength. In the following statement just issued by the National Citizens Committee, every nurse who works with children will recognize her own responsibility:

The National Citizens Committee, created by the White House Conference on Children in a Democracy to give national leadership in making the Conference recommendations effective, is convinced that the program adopted by that Conference will make for the national unity so sorely needed at this time, and will strengthen the democratic insti-

tutions of our country. The Committee believes that child welfare and national security are inseparable and affirms that:

1. The defense of democracy calls for the appreciation of the dignity and worth of the individual and concern for the young, the helpless, the needy, and the aged. Support of public and private services for children should be sustained as an essential part of a national defense program.

2. National effectiveness requires further development of coöperation and self-discipline among our citizens. To

NOTE: Photograph from *All the Children*, Forty-first Report of the Superintendent of Schools, City of New York.

destroy our liberties in an effort to protect them would be a tragic blunder. Denial of civil liberties, resort to mob action and other extra-legal procedures, and throttling of free discussion of public issues will not advance the cause of democracy at home or abroad.

3. To be strong a people must be well nourished. Proper food for mothers and children depends upon such factors as agricultural production and distribution, maintenance of family income, and education in nutrition.

4. Health services and medical care for all, particularly for mothers, children, and youth, should be maintained and extended.

5. Educational opportunity adapted to present-day needs should be made available to all children, to youth until they secure employment, and to adults as required for vocational efficiency and for citizenship.

6. Standards now provided under federal and state child labor laws should be preserved, and similar safeguards should be extended to children needing but not now receiving such protection. The national strength does not need the labor of children.

7. Work opportunities should be made available for all youth who have completed their schooling, with necessary safeguards for their health, education, and welfare.

8. The gains under federal and state legislation for the conservation of home life for children in need should be maintained and developed, with more active state and local participation.

9. We must consider ways in which we may help to safeguard the children of other lands from such misfortunes as hunger and homelessness. We cannot consider the needs of the children of this nation and ignore the hardships visited upon children elsewhere.

10. The social gains of the past decade should be maintained in the present critical period. Standards of family living should have an important place in the program of the Advisory Commission to the Council of National Defense. The Advisory Commission should consider ways in which health, educational opportunity, and the social well-being of families and their children may be conserved and advanced as essential elements in a national defense program.

HOW CAN SCHOOLS USE THE LAYMAN?

HOW MUCH use is being made of the layman in our school health services? Does not school nursing, of all the phases of public health nursing, offer one of the best opportunities to use lay people? Everyone is interested in helping children. It may be their own children who are concerned, or someone else's. Almost every individual in a community can be aroused to assist, if he only knows what the problems are and what to do.

"How can School and Community Join Forces to Serve the School Child?" was the title of a stimulating panel held

at the Biennial Convention in Philadelphia and summarized in the August issue of *PUBLIC HEALTH NURSING*. (Page 482.) Throughout this report, the writer felt that here again were opportunities for using lay people—to assist in developing a community council, to stimulate better recreational facilities for the school child, to work for more adequate housing.

Boards of education are comprised of representative citizens of the community, and some of the women members who have been active in educational work welcome an opportunity to be

brought more closely in touch with the school program itself. Also, in many schools there are excellent parent-teacher associations. The program of the National Congress of Parents and Teachers, carried out through its state and local branches, emphasizes health as one of its major features and has done much in furthering the preschool round-ups. But often these local groups have not been brought in close contact with the school health program, which could be one of their major interests.

The whole philosophy of community service emphasizes that no one group can do it alone. The expert, the professional worker, the technician are the ones to carry on the actual program; but they need community understanding, community backing, and community support to do their job effectively. The layman, working side by side as a partner with the professional worker, can do much not only in actually giving service but in interpreting back to the community, back to the taxpayer, back to the voting public, the value and the need of the service.

Various types of organization are possible for school health committees. Where there is a good and active parent-teacher association, the school physician and nurse have a nucleus for such a committee already present in the health committee of the P.T.A. To this group could be added a representative from the board of education, a representative from the older student group, the health officer or his representative, and perhaps someone from the other local health agencies, such as the visiting nurse association.

Where there is no active parent-teacher association, possibly a woman representative from the board of education might assist in organizing a health committee. The important thing in planning lay participation is that the committee shall be representative of the various groups in the community who

have an interest in health and who have time to give to the health work.

To this committee, meeting regularly, the school nurse could bring her reports, and the committee could assist in various ways; for example, in providing scales and other equipment for the physical examination; in assisting the school doctor and the nurse at the time of the health examination; in making available hot school lunches where the children are not able to provide their own; in tapping community resources to meet special needs of children for correction of defects or for recreation.

The most important factor in the success of the committee is to keep the members closely in touch with what the professional workers are doing and to see to it that there is something worth while for the layman to do. Today, with the multitudinous demands on everybody's time for assisting in community activities, national programs, and international appeals, laymen are not going to be passively interested in a program. They will serve only where they believe their service is going to count for something.

Do you have a health committee organized as a part of the school health program? Have you used volunteers to assist in various ways? How are you keeping this committee in touch with the work? These and other questions come to our minds. In order to give practical help in furthering lay participation in the school health program, an exchange of ideas would be beneficial to us all. Won't you write us what your community is doing to use the layman in the school health work—be it ever so modest a beginning?

Certainly there is no place in the entire community health program where the citizen should have more active interest than in assisting with the health work for our children. Here is their opportunity to build a better community!

E. K. D.

Health in a Progressive School

By ALFHILD J. AXELSON, R.N.

Health in this progressive school is the concern of the school as a whole, including the parents, and becomes a part of the children's day-by-day experience

PROGRESSIVE education emphasizes the fact that it is important for children to live fully at each stage of development. In this way they can grow up to meet life as mature individuals, physically, mentally, emotionally, and socially. In this kind of a philosophy, health plays an important role, for in order to live fully, to work and play with constructive purpose and enthusiasm, children have to be sound in body and in mind.

To help children realize this all around development is a basic concern of Lincoln School, an experimental progressive school of Teachers College, Columbia University. This school, founded in 1917, includes primary, elementary, and secondary grades. It usually has an enrollment of about five hundred children whose ages range from three or four years—as represented by children in the nursery school—to about seventeen years, the average age of students in the twelfth grade.

Health in Lincoln School is the responsibility of everyone connected with the institution—the administrators, the teachers, the specialists, the children, the custodian of the building and his staff, and the parents whose active participation in the life of the school is one of its distinguishing features. And the health program is integrated with the child's living and learning in the school.

In this description of the program the contribution of three factors will be discussed: the environment, health education, and the health service.

The building offers a wholesome place in which to live, healthful from a physical and aesthetic standpoint. The rooms are large and can be well ventilated. Many of them have sunny exposures. The artificial lighting is not, however, of the modern, indirect type. Most of the rooms are pleasingly individual in color scheme and decoration, the high school students having assisted in the decoration and in some instances in the furnishing of their rooms.

The health office, a ground floor three-room suite with storage closets and a lavatory, is cheerful in appearance. The walls of two rooms and one hall are yellow, and those of the third room and an entrance hall are a soft gray blue. The woodwork is white throughout.

All the doors opening into rooms on the first floor are a gay, lacquer red, which, as one articulate boy of six expressed it, "make you want to open them to see what is behind them." The facilities of the school are favorable for hygienic practices. There are movable and adjustable desks or chairs; sanitary drinking fountains; provision for recreation in a school swimming pool, in gymnasiums, on the roof, on the school grounds, and in a few of the city parks to a limited extent; rest rooms; and lavatory facilities.

Principals, teachers, and specialists cooperate in trying to plan the school program so that it meets the needs of each age group of children. There is experimentation to create a balance of

rest, recreation, and classroom activity. An important consideration for mental and emotional health is the flexibility of the program throughout the school, which allows each child to develop according to his individual abilities.

No one could be associated with the school long without appreciating that guidance is inherent in the program. There is a consistent effort to help children, individually and in groups, toward wholesome growth. Creative interests, social attitudes, and emotional stability and physical health are all considered important.

Teachers of the primary and elementary divisions and class advisers in high school are chiefly responsible for individual guidance, which is not under the direction of any one person. They know children, and they know well the individual children in their groups and the parents of these children. These teachers seek help from other teachers, and particularly from the psychologist, physician, nurse, nutritionist and physical education teachers. Frequently this is done by means of group conferences.

Health counselling, carried on with students and parents, is an important phase of the work of the school physician and nurse.

Indispensable for all the aspects of guidance are the cumulative records of health findings, psychometric tests, and the primary and elementary teachers' periodic summaries of children's achievement and personality development. Because of the continuity of the program, extending as it does from nursery school through high school, these records are particularly helpful.

EDUCATION IN HEALTHFUL LIVING

Because health is in the main a matter of personal accomplishment to be gained through healthful practices in living, health education is the most vital, far reaching, constructive ap-

proach to building good health in children. Everyone will concede that the provision of facilities for healthful living will not in itself make children self-directing in the practices which are necessary for health.

In Lincoln School, children have an opportunity to gain an understanding of the functioning of their bodies and the requisites for healthful living through activities in household arts which particularly stress nutrition, through classes in biology, in integrated units and courses, and in conferences with the physician and nurse.

THE NURSE'S PARTICIPATION

Participation of the nurse in classroom activities may grow out of a request by the teacher or a suggestion of the nurse. An instance of the latter is the following. The children of the sixth grade were studying Greek and Roman cultures. The nurse suggested that the children might gain a keener appreciation of the art of these peoples by knowing about the medical beliefs and practices of those times, since Greek and Roman art draws so freely from medicine for its decorations of vases and utensils and for its sculpture. As a result we all—teacher, nurse, and children—became interested in the teachings of Hippocrates (marveling at the fact that they are so modern) in the origin of modern medicine, and in the early hospitals, comparing them with present-day institutions. We studied histories of medicine and the writings of Hippocrates, and examined slides on the history of nursing.

Again, a fourth-grade science group was learning about oxygen, which brought out the significance of oxygen to life. The children wanted to know how oxygen got into the body. In this instance, it was the teacher who asked the nurse to work with the children in an activity to study the respiratory and

circulatory systems. For this purpose we used specimens of a heart and lung obtained from the butcher, and a manikin with removable organs, known throughout the school, even by the porters, as "Susie."

Susie's home is the health office, from which she travels out all over the building to classes that need her. Children from about the age of nine enjoy taking her apart and putting her together again, learning the names, functions, and relative size and positions of the organs of the body. Children not infrequently make special appointments with the nurse for this purpose.

Most of the classroom contacts of the nurse with the high school grow out of the fact that the nurse is a member of a small group of teachers responsible for the program of one grade. In the ninth grade, with which the nurse has worked for a number of years, this group has consisted of the class adviser, the teachers of science, household arts, and physical education, and the nurse.

One of the functions of the nurse, in addition to sharing in the planning of the work, is the arrangement and conducting of field trips to hospitals, clinics, health centers, and welfare organizations. She has also been responsible for planning the follow-up discussions after these excursions.

This is only a very superficial picture of health education in Lincoln School, which is not a set program because of the experimental nature of education in this school, and because health education is chiefly a matter of activities growing out of integrated courses.

HEALTH SERVICE IS EDUCATIONAL

Health service, commonly thought of as comprising health appraisal, correction of defects, and health protection, is to a great extent educational in nature in Lincoln School. The emphasis is upon health rather than illness.

The service is under the direction of the health division, staffed with a part-time school physician in charge of all medical aspects of the health program; a full-time nurse in charge of the school nursing aspects of the program including the direction of the health office; and a part-time nurse who acts as secretary and assists in health counseling and first aid.

Each child has a physical examination by the school physician every year. At the time of the first examination, when the father or mother is present, a developmental health history is taken in narrative form. This is brought up to date yearly. Parents are also present for all examinations of young children under six and special examinations requested by teachers or parents.

The nurses assist in taking health histories and in the testing of visual acuity and hearing. Children who have a hearing loss of 9 percent or more according to 4A audiometer tests, or whose hearing ability the teacher questions, in spite of satisfactory test findings, are given a 2A audiometer test in the guidance laboratory of Teachers College.

A written report of physical examinations is sent to parents who are not present at the time of the examination. These reports frequently result in conferences of parents with the physician or nurse.

TEACHERS RECEIVE REPORTS

Teachers are also given a brief, pertinent report of the physical findings of children of their group. A two-way report form is used for this purpose with the names of all children in a group included on it. This form allows for a return report of significant information from the teacher to the nurse.

The correction of physical defects is the responsibility of parents. The school physician, nurses, and teachers

coöperate closely with the family physicians or specialists in securing necessary treatment, and especially in relation to a child's need for a special program.

For health protection, the causes of absences are checked carefully by the nurse. Most of the children in school have telephones, and the parents call the health office to report the reason for an absence—which is encouraged—or the nurse calls the home of the absent child.

Individual records of attendance and the daily census for the school, with causes of absences, are kept in the health office by the assistant school nurse. A large sheet of graph paper about three feet by two feet is used for the records of each group of children. These reports are open to teachers, who consult them freely. Almost at a glance one can trace on these records the results of contacts with communicable disease.

CHILDREN REPORT ILLNESS

To prevent communicable disease, parents are advised to keep children who are not well at home, and children are encouraged to report to the health office if illness develops at school. Even very young children learn to do this and do it objectively. They seem to be able to appreciate the close relation between individual and group health.

If communicable disease does occur in school, letters signed by the school

physician are sent to parents of all children in the group who have been exposed. These letters give the early symptoms of the disease to which the child has been exposed, the dates of the incubation period, the need for examination of other children at home, and the information that children are to report to the health office each school morning of the incubation period for examination before going to classrooms.

These phases of health office procedures and many others are natural and effective means of children's health learnings. They not only learn about the nature of bacteria in learning to do their own first aid, but they acquire first-hand information about their bodies, such as the length of time it takes blood to clot, and the way a wound heals.

In summary, the chief values of the health program at Lincoln School lie in the fact that health is the concern of the school as a whole, including the parents, and that it is integrated with the life of the school. Through this integration, health maintains its relative importance as a means by which to live fully and never becomes an end in itself.

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October first is the time and *P.H.N.* the name. On or about this date the postman will bring it to every member of the National Organization for Public Health Nursing. Watch for *P.H.N.*

Evaluating Health Education Materials

By BESS EXTON

The public health nurse is frequently asked to help the teacher secure and select authoritative and educationally sound materials for use in health education

THE PHILOSOPHY of general education has been undergoing critical and constructive analyses, due primarily to social changes now under way in schools, business, government, labor, social service, and other agencies which are rapidly changing the patterns of life. Concepts and procedures have changed to such an extent that the so-called extracurricular activities of the schools of yesterday bid fair to be the curricular activities of tomorrow. The schools of today have been described simply and effectively as follows:

The school is a place where wholesome and complete living goes on; where teachers, parents, and pupils accept each other as equals. It is a cooperative relationship like that which exists in the finest home and is characterized by love, affection, and mutual respect.*

The schoolroom of yesterday whose sole adornment was one picture (generally that of President Washington) and one large dictionary is rapidly passing. These two articles were the only supplements to desks, seats, and state-adopted textbooks. These textbooks were in use for periods of five or ten years, were memorized from cover to cover by succeeding members of the family, and were purchased by the

parents. What a difference today! In varying degrees, all schoolrooms are really workshops today. They resemble a well equipped carpenter's shop or a home with its essential furnishings.

TRENDS IN HEALTH EDUCATION

The philosophy and purposes of health education are essentially the same as those of general education. Some progress has been made in health education during the last decade. Studies show that while our national health has improved, there is still a tremendous amount of illness as well as deaths which can be prevented. We can venture a guess as to the numbers on the border line between sickness and health. Sanitation and immunization have been two effective tools. We are beginning to join our forces in a third area, that of health education, and make our nation the healthiest one possible. For the first time *the individual* is receiving the major attention, and many different techniques must be used in this educational endeavor.

The most effective method of getting an individual to assume responsibility for his own health over both a long-range and a short-range period and before illness overtakes him is still largely unknown. Our people are aware of the big problem they are facing and already have their forces at work all over the United States. The White House Conference on Children in Democracy set up recommendations to be carried out this coming decade. Their aim is to

*Alexander, Fred M. "What Is Evaluation?" *Virginia Journal of Education*. (Official publication of the Virginia Education Association, Richmond, Virginia.) May 1939, p. 344.

promote the kind of democracy and the kind of living that American citizens desire for each and every child living in this country.

WORKING TOGETHER

National organizations have realized for some time that special interest groups when united for a common purpose can be tremendously effective in solving problems. Accordingly a conference was called in New York City last November comprised of delegates representing some fifty national organizations interested in the school health program. These included the United States Public Health Service, the United States Children's Bureau, the American Red Cross, the American Medical Association, the American Dental Association, the National Education Association, the National Health Council, and several of the Council's member organizations—including the National Tuberculosis Association and the National Organization for Public Health Nursing.*

All realized that school health work is but one aspect of the community health program. The schools, being charged with the promotion of education among adult groups as well as among children, should assume the leadership in the health education program. There was established, not another independent organization, but a National Conference for Coöperation in School Health Education.** Some state and local communities already have similar set-ups. It is hoped that such a plan of coördination will soon be common throughout the United States. The possibilities of such conferences on a national, state, or

community basis are tremendous. They can serve as a channel for discussion, for the setting of standards, for the directing of groups such as publishers to authoritative sources of health materials, and for many other activities to improve the school health education program.

SELECTING HEALTH MATERIALS

Materials for use in health education are available from a wide variety of sources today, and it is a responsibility of those concerned with education in school and community to determine whether such materials are accurate, whether they meet the needs, and whether they are chosen on the proper level for those who are to use them. The teacher, the nurse, the pupil, and the parent may very well have a part in the assembling of materials. They not only can help select materials but can also make contributions of professional and other magazines, pamphlets, and clippings to the health library shelf.

Responsibility for the evaluation of health education materials may be delegated to a representative committee in the school. Such a committee should allow ample time, should be careful in the spending of monies available, and should possess special skill in the evaluation of books and other materials. One who wishes to cultivate such skill will find *Subscription Books Bulletin*, published by the American Library Association, 520 North Michigan Avenue, Chicago, Illinois, of great value. Local libraries will be able to give information on this bulletin.

Of the 48 states only 17 permit local boards of education to adopt textbooks. The schools in these states are able to meet local needs more adequately. However, the trend in all states toward constant curricular revision and better school libraries is challenging boards of education to provide better equipment, textbooks, and supplies. These should and are being considered solely from the

*A list of the participating organizations is available from the American Association for Health, Physical Education, and Recreation, a Department of the National Education Association.

**Dr. C. E. Turner of the Massachusetts Institute of Technology was elected chairman, and Dr. N. P. Neilson of the National Education Association, secretary.

standpoint of their value in facilitating the instructional process.

CRITERIA FOR EVALUATION

It is advisable for a school to build its own guide for evaluation of materials. It may add to or deduct from this list each year.* As a beginning, important points in evaluating materials may be listed as follows:

1. *Scientific accuracy*

Note the author and ascertain whether he is recognized as an authority in his field. His professional connections will offer a guide in determining his standing. It is regrettable that check lists which allot only five to ten points for scientific accuracy have been evolved for the rating of textbooks. In this complex, moving world persons responsible for the education of youth have time only for the most up-to-date scientific material. Material is either scientific or not scientific, or it is material which we accept upon recognized authority as providing the best guide to follow until further research reveals the scientific information sought. This material must be impartial in outlook and must be prepared in scholarly fashion.

After checking on the author, look up the date of first printing. If later dates are given, be sure to find out whether the publication is a revision or merely a reprint.

By allowing ample time one may compare the information on topics such as the skin and the body systems in the different textbooks from which a selection is being made. From such com-

parisons the group will eventually decide which book meets the needs of their particular setup.

2. *Format*

The appearance of books, pamphlets, magazines, charts, posters, and other educational materials is important. Publishers tell us that in no other field have they made greater progress in the format or style of books than in the textbook area. In considering format one will need to ask such questions as: Do these materials conform to the recommendations of specialists in the conservation of eyesight, in regard to the color and kind of paper, and the size, spacing, and clearness of type? Are artistic standards maintained? Are the materials easy to handle? Will they wear well?

The artistic quality of textbooks is the outstanding accomplishment of this decade, which has seen the standard and quality of textbooks continuously improved. The importance of visual education, which is recognized today in schools, demands that textbooks or other materials be illustrated in a highly artistic manner, possess attractive typography, and have distinct photographic quality. If colors are used in cover, paper, type, or illustrations, they should be clear, simple colors, attractive to the young child. The most effective posters and wall charts are simple and artistically pleasing, with brief and legible lettering. A poster should express only one idea and should be free from excessive detail.

One must see that books selected for children are not too large for the child to handle easily. The book should not have a cover with slippery finish. It should be well hinged so that it opens easily. It should open to a good, full extent so that it can be placed on the

*Arthur B. Moehlman states in his new book, *School Administration* (Riverside Press, Cambridge, Massachusetts, chapter 19, p. 433): "The textbook may be rated by use of some standard appraisal form from the standpoint of classroom use, basic materials, point of view, vocabulary, relation to dominant method within the system, content, mechanics, and distinctive elements . . . The book may then be appraised for its expression of curricular objectives and tested under classroom conditions."

*The National Society for the Prevention of Blindness, 50 West 50 Street, New York, N.Y., is a source of information on these points.

desk without closing itself. All books or supplementary materials should fit in the storage places which are provided in the schoolroom.

With modern processes and inventions our books of today can and should be made of materials which wear well. A brief examination will show whether a book contains covers and pages of good, strong quality. It should be well bound, and should be sewed and glued in such a way that it will not fall to pieces in too short a period of time.

3. *Bibliographies*

The busy teacher will appreciate extensive, up-to-date, accurate references of sources from which factual statements are taken. Pupils who are interested in special topics may want to pursue the matter further. If legendary, mythological, historical, or biographical approaches are used by the author, good bibliographies are essential as guides in looking up source materials so that the child will have a clear and complete picture of his reading.

4. *Instructional value*

This is complex. It involves a constant reappraisal and revision of the curriculum. What are the methods of teaching so that *how* to live healthfully and *why* will become meaningful to each child? Does the material take into account the coordination of school and community? Young people should know not only their personal health assets but the resources of their community as well. Is the information presented stimulative, pertinent, significant to the group? Is it presented as a simple, continuously developing experience? Is the language concrete and graphic?

Whether teachers can have few materials or many for the children to use, they are increasingly concerned with the ability of children to use the facts which they learn. Children need to be able

to judge each other's ideas and those they read in the books, magazines, or newspapers, hear over the radio, or meet in other ways, and to cultivate the ability to evaluate critically. Health instruction should not be separated from other aspects of the health program or from the total education of the child.

The public health nurse has a unique contribution to make in this connection. Being the liaison person who interprets the home to the school and the school to the home, she carries on a parent education program which goes hand in hand with a good health teaching program.

SOURCES OF MATERIALS

In addition to the organizations which comprise the National Conference for Cooperation in School Health Education mentioned previously, there are numerous sources from which one may obtain education materials. Such sources include:

- Health departments—state and local
- Nonofficial health agencies—national, state, and local
- Publishing companies
- Foundations
- Commercial organizations
- Insurance companies
- League of Women Voters
- Universities and colleges
- The two World's Fairs

There are other sources, too, which are valuable to teachers, nurses, and others who are promoting a health education program, for example:

1. The Bureau of the Census, Washington, D.C. The 1940 census when compiled and analyzed will be a valuable guide in formulating a health education program. Census tracts are used in our larger cities. They are rather expensive, but because of their value as a guide in showing population trends and problems in the several age groups, they represent a wise expenditure of funds. Newspapers and magazines will have articles analyzing the 1940 census for

months to come. A scrapbook composed of these clippings pertinent to health would prove splendid source material for all groups.

2. Library of the Office of Education. This, the largest education library in the world, makes available facilities for extensive study and research in health education. Each year a classified bibliography of research undertaken in colleges and universities is published. The library serves the whole country through a system of interlibrary loans. In looking over the studies on file, a master's thesis by Jess V. Cooper (University of Kansas, 1937) is an example of many. Mr. Cooper found in a survey made of ten periodicals for twelve months that *The Reader's Digest*, *Time*, and *Collier's* contain sufficient material to be used as supplementary sources in biology, and that the dominant biological interest of the public pertains to human biology, particularly the health aspects. This Bibliography of Research Studies in Education may be purchased from the Superintendent of Documents, Washington, D.C., for 35 cents.

3. The White House Conference on Children in a Democracy. The general report of this Conference, "Children in a Democracy," concludes with the following statement: "... the conference pledges its members and calls upon all other citizens to press forward in the next ten years to the more complete realization of those goals for American childhood which have become increasingly well defined from decade to decade and to which the foregoing pages have given expression." This report, published on January 19, 1940, is available from the Superintendent of Documents, Washington, D.C., for 20 cents.

4. United States Public Health Service. Vital statistics which will be invaluable in formulating and appraising health programs are found in the weekly *Public*

Health Reports of this organization. They are available from the Superintendent of Documents, Washington, D.C., at \$2.50 a year.

5. Radio scripts. At various times health broadcasts are given. Copies of these are generally available for a small fee from the station in which they originated. A radio project is carried on under the Office of Education, in which the National Broadcasting Company and the Columbia Broadcasting System and their affiliates cooperate and to which they contribute funds. Many other interested agencies contribute funds and cooperate extensively in the production of programs.

The radio division of the Office of Education has promoted education by radio in local communities by establishing the Educational Radio Script Exchange, which now lists more than 500 script titles. Some of these are concerned with health, and if there is enough local interest in promoting health programs, an increase in both quality and quantity should be possible. A catalogue is available from the Educational Radio Script Exchange, U. S. Office of Education, Washington, D.C., for ten cents.

6. United States Film Service. This film service distributes government films to schools, colleges, adult educational groups, and other organized groups. It will be glad to assist both in obtaining films and in planning educational picture programs. A Directory of United States Government Films is available upon request. The directory lists also all government agencies having film strips and lantern slides for distribution.

Some of the health films listed are: Food Makes a Difference; In the Beginning; Three Counties Against Syphilis; The Feet; Posture; and Housing in Our Time. There is listed a set of lantern slides on Birth and Mortality

Statistics. As additional service to schools the Film Service has prepared special study guides; has published the U. S. Government Film Chart, listing federal motion pictures for use in visual education; and has prepared bibliographies, lectures, and other materials on motion pictures. Information can be secured from the United States Film Service, Office of Education, Washington, D.C.

7. The Gallup surveys. Everyone is familiar with the Gallup polls. Some have been concerned with health problems such as tuberculosis. These are valuable when leaders or pupils wish to conduct a survey in their school or community. They are brief but are worded carefully so that when the answers are compiled, a fairly accurate picture of the problem is presented. Information on these polls is available from the American Institute of Public Opinion, 110 East 42 Street, New York, N.Y.

8. County medical and dental societies are able to secure health films and other materials from their national organizations.

9. State and local health departments, health divisions of school departments, and other agencies concerned with health education prepare lists of sources of health materials. Two such lists are:

Sources of Supplementary Materials in Health Education, a project of the Health Instruction Section, which was presented at the annual meeting of the

American Association for Health, Physical Education, and Recreation in Chicago. This is available from the Association, 1201 Sixteenth Street, Washington, D.C.

Bibliography on Health, Physical Education, and Recreation, No. 61, 1939, listing all the publications on health that have been published by any agency of the United States Government. It is available from the Superintendent of Documents, Washington, D.C.

Nurses who work closely with all organizations and who keep tapping all available community channels will find stores of materials concerned with health. The domain of health education is so vast and its literature is so extensive that teachers, nurses, parents, and pupils need to be alert. This will take purposive, intelligent, concerted effort on the part of many people and groups.

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A Tentative Code for the Nursing Profession which has been prepared by the Committee on Ethical Standards of the American Nurses' Association will appear in *The American Journal of Nursing* for September. Representatives from various fields of nursing served on the committee which prepared the code. It is published in the hope that nurses will read it thoughtfully and analytically to see whether they believe it will be helpful as a guide to professional conduct. Public health nurses are invited to send their comments and suggestions to the American Nurses' Association, 50 West 50 Street, New York, N.Y.

What Is the Truth About Teeth?

By WILLIAM R. DAVIS, D.D.S.

Authoritative source material for health education is in constant demand by school nurses, who will welcome this first article in a series on dental health

THE FACT that teeth are an important part of the human anatomy, and that their condition may have a very direct bearing upon health is accepted today by all the health service professions. However, many nurses are confused by conflicting statements concerning teeth which seem to emanate from sources that should be reliable and they wonder what are the facts. Unfortunately, statements of opinion are often given out as facts or are soon repeated as facts. Consequently, a folklore develops and statements continue to be passed along which may be hoary with age and yet have no foundation other than somebody's former opinion which later research may have proven false. Last year a dental committee examined the dental content in about eighty textbooks on health intended for use in schools and did not find one wholly acceptable. Most of them had much false teaching in regard to teeth.

It is hoped that this series of articles presented under the auspices of the American Dental Association will help to clarify the subject. We will try to give the most authentic information, and where there is doubt, to qualify. Nurses are in an especially strategic position to aid in dental health education and should have as correct information as is obtainable.

An effective program of education in dental health requires some understanding of the histology and anatomy of the teeth. According to Kronfeld,* tooth development in man begins be-

tween the thirty-fourth and thirty-eighth day of fetal life with a proliferation of the epithelium covering the jaw ridges. From this the tooth buds develop. These cells are going to lay down the future enamel of the teeth and will atrophy when the enamel is complete. They of course will entirely disappear when the teeth erupt and hence no cells remain to change enamel afterwards. Kronfeld says, "Until some new evidence is brought forth, the conclusion must be that the calcium content of the enamel does not change once the tooth is erupted, and that the calcium content of the dentin also remains stable, or increases slightly during life, but never decreases. Unlike the bones the teeth are not subject to calcium withdrawal."**

✓ Calcification of the deciduous teeth, also called baby or foundation teeth, begins at from four to six months *in utero*, and the amount of the enamel and dentin present at birth can be determined by the neonatal ring, which is a microscopic line dividing the prenatally formed tooth structure from that postnatally formed.

✓ Calcification of the permanent teeth begins at birth with the cusps of the first

*My chief authority in this discussion is the late Rudolf Kronfeld, M.D., D.D.S., whose research, textbook, and articles on this subject are considered by the dental profession to be outstanding.

**Kronfeld, Rudolf. *Histopathology of the Teeth and Their Surrounding Structure*. Lea and Febiger, Philadelphia, second edition revised, 1939, p. 33.

MICHIGAN DEPARTMENT OF HEALTH

Chronology of the Human Dentition

Logan and Kronfeld (slightly modified by McCall and Schour)

Tooth		Hard tissue formation begins	Amount of enamel formed at birth	Enamel completed	Eruption	Root completed
Deciduous dentition	Upper	Central incisor	4 mos. <i>in utero</i>	Five sixths	7½ mos.	1½ yrs.
		Lateral incisor	4½ mos. <i>in utero</i>	Two thirds	9 mos.	2 yrs.
		Cuspid	5 mos. <i>in utero</i>	One third	18 mos.	3½ yrs.
		First molar	5 mos. <i>in utero</i>	Cusps united	14 mos.	2½ yrs.
	Lower	Second molar	6 mos. <i>in utero</i>	Cusp tips still isolated	24 mos.	3 yrs.
		Central incisor	4½ mos. <i>in utero</i>	Three fifths	6 mos.	1½ yrs.
		Lateral incisor	4½ mos. <i>in utero</i>	Three fifths	7 mos.	1½ yrs.
		Cuspid	5 mos. <i>in utero</i>	One third	16 mos.	3 yrs.
Permanent dentition	Upper	First molar	5 mos. <i>in utero</i>	Cusps united	12 mos.	2½ yrs.
		Second molar	6 mos. <i>in utero</i>	Cusp tips still isolated	20 mos.	3 yrs.
		Central incisor	3 - 4 mos.	—	7 - 8 yrs.	10 yrs.
		Lateral incisor	10 - 12 mos.	—	8 - 9 yrs.	11 yrs.
		Cuspid	4 - 5 mos.	—	11 - 12 yrs.	13 - 15 yrs.
		First bicuspids	1½ - 1¾ yrs.	—	10 - 11 yrs.	12 - 13 yrs.
		Second bicuspids	2 - 2½ yrs.	—	10 - 12 yrs.	12 - 14 yrs.
		First molar	at birth	Sometimes a trace	6 - 7 yrs.	9 - 10 yrs.
	Lower	Second molar	2½ - 3 yrs.	—	12 - 13 yrs.	14 - 16 yrs.
		Third molar	7 - 9 yrs.	—	17 - 21 yrs.	18 - 25 yrs.
		Central incisor	3 - 4 mos.	—	6 - 7 yrs.	9 yrs.
		Lateral incisor	3 - 4 mos.	—	7 - 8 yrs.	10 yrs.
		Cuspid	4 - 5 mos.	—	9 - 10 yrs.	12 - 14 yrs.
		First bicuspids	1¾ - 2 yrs.	—	10 - 12 yrs.	12 - 13 yrs.
		Second bicuspids	2¼ - 2½ yrs.	—	11 - 12 yrs.	13 - 14 yrs.
		First molar	at birth	Sometimes a trace	6 - 7 yrs.	9 - 10 yrs.
		Second molar	2½ - 3 yrs.	—	11 - 13 yrs.	14 - 15 yrs.
		Third molar	8 - 10 yrs.	—	17 - 21 yrs.	18 - 25 yrs.

permanent molars, and enamel formation of all the permanent teeth except the third molars or wisdom teeth is completed by the end of the eighth year. Appended to this article is a table showing the chronology of the human dentition for both the deciduous and permanent teeth, which nurses will find helpful in answering many questions asked them concerning the teeth.

THE EXPECTANT MOTHER

The statement is often made that the diet of the pregnant woman is very important from the standpoint of good dental development in the fetus. The researches of Kronfeld, Schour, Hess, and Stein* all seem to contradict this statement, since the total amount of mineral salts present in the teeth of the newborn infant is only about 0.5 gm., which is too small to be influenced by the maternal diet. This of course does not obviate the fact that good nutrition for the expectant mother is very desirable for other reasons.

✓ Also, they show that good nutrition from birth to eight years of age is very important in building well formed teeth—it is important till fourteen years if we include the third molars. This includes the entire formation of the crowns of both deciduous and permanent teeth.

✓ Serious diseases such as scarlet fever or other disturbances during the first or second year of life may cause imperfect enamel of the permanent teeth, which

may be disfiguring when these teeth later erupt. Mottled enamel, a chalky, white, brown, or black discoloration, and pitting may be caused by the presence of soluble fluorine salts in the drinking water and this is quite a problem in some sections of the country. It only happens during infancy and childhood when the teeth are forming. After the teeth are formed the water has no disturbing effect.

A tooth is divided into two parts: a root or roots which anchor it in the jawbone, and a crown—the visible portion in a normal mouth. The junction of the crown and root is called the neck and is slightly constricted. Within the crown is a pulp chamber, and within the root, a pulp canal.

THE PICTURE OF A TOOTH

✓ A tooth is composed of four different tissues. (See illustration.) The enamel (a) is a hard, glistening substance which covers the crown only. The cementum (b) is a bonelike substance which covers the root portion only. The dentin (c) is an ivorylike substance which forms the bulk of the crown and root. The dental pulp (d) is composed of connective tissue containing nerves, arteries, veins, and lymphatics which enter at or near the apex of the root or roots. This occupies the pulp chamber and root canals. The pulp is pink in the normal condition and is often erroneously called "the nerve." Covering the root or roots of the tooth and lining the walls of the socket in the bone (e) is a layer of tissue called the periodontal membrane (f). This membrane helps to hold the tooth in place and also acts as a cushion to lessen the shock caused by the teeth coming together in mastication.

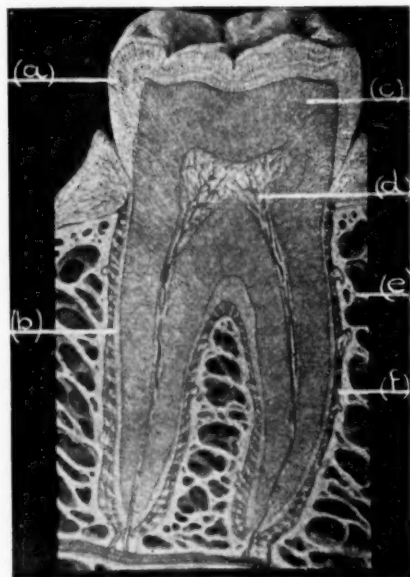
Teeth have different shapes because they have different functions to perform. Space does not permit a detailed description, but the names give a good indication. These are: incisors, cuspids, bicuspids (two cusps), and molars.

*Gordon, Samuel M. Dental Science and Dental Art. Lea and Febiger, Philadelphia, 1938.

Benjamin, H. R., and Hess, A. F. "Forms of Calcium and Inorganic Phosphorus in Human and Animal Sera, Normal, Rachitic, Hypercalcemic, and Other Conditions." *Journal of Biological Chemistry*, March 1933, p. 27.

Hess, A. F., Lewis, J. M., Roman, B. "A Radiographic Study of Calcification of the Teeth from Birth to Adolescence." *The Dental Cosmos*, November 1932, p. 1053.

Stein, Georg. "Schmelzshaden am Milchgebiss und ihre Klinische Bedeutung." *Zeitschrift für Stomatologie*, Berlin, July-August 1936, p. 843.



- (a) Enamel
- (b) Cementum
- (c) Dentin
- (d) Pulp
- (e) Bone
- (f) Periodontal membrane

Longitudinal section of a lower molar tooth

There are 20 teeth in the deciduous set, 10 in each jaw. There are no bicuspids in the deciduous set. The molars come in right behind the cuspids, which are sometimes called "eye teeth," in the upper jaw, and "stomach teeth" or "canines," in the lower jaw. However, the cuspids have no special relation to the eye or stomach. The deciduous teeth are usually lost between the sixth and fourteenth years. Because of their importance in health, mastication, and speech, as well as to give form and symmetry to the face, they should be kept in a healthy condition until they are replaced by their permanent successors. Contrary to popular opinion, deciduous teeth do have long roots. These roots, however, gradually resorb as the permanent teeth get ready to take their place. But if the deciduous teeth become diseased, the roots often do not resorb and this is one of the most important causes of crooked permanent teeth. The permanent teeth are then crowded out of line.

There are 32 teeth in the permanent set, and these usually erupt between the

sixth and fourteenth years, except the third molars or wisdom teeth. The first permanent tooth to erupt is usually the first molar, known as the sixth-year molar. It is the largest and one of the most important teeth in the set and comes in right behind the deciduous molars; consequently it is often mistaken for a baby molar. It is well to remember that the twelve permanent molars do not replace any deciduous teeth but come in behind the location of the deciduous teeth as the jaws become longer.

✓The eruption time of the permanent as well as the deciduous teeth varies considerably in different individuals, as can be seen from the appended chart. Sometimes certain teeth are missing, nature never having formed them, and this can always be determined by an x-ray picture. Sometimes also nature supplies one or more supernumerary teeth. These are usually of no use because they are out of line or crowded between teeth and may need to be extracted. Contrary to popular opinion there is no authentic evidence that any person ever gets a

third set of teeth—except artificial ones.

One of the most important facts to remember about the structure of the teeth pertains to pits and fissures in the enamel. When the crowns of the teeth are forming in the jaw before eruption, calcification of the enamel proceeds from individual centers and gradually covers the entire crown. Where the edges come together there should be complete fusion. But often even in the best quality of teeth, this does not occur and we have a circular opening called a pit, or a deep cleft called a fissure. These are favorite places for decay to start because they

are too small to be seen or kept clean by any means. This is why it is so important to start having the teeth examined soon after eruption, for a careful dental examination will discover these defects and filling can be inserted in time to prevent serious damage. When decay penetrates to the dentin, which is less dense, it proceeds much more rapidly and a large cavity may develop before it is discovered.

This is the first of a series of articles by various authorities on dental health, presented by the Dental Health Education Committee of the American Dental Association.

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The Supervisor of School Nurses

By VERA B. MCGUIRE, R.N.

Some practical and helpful suggestions are given here regarding the work of the supervisor of school nurses

THE SUPERVISOR of school nurses is a very important part of the school system. Her relationships with the nurses, the school personnel, the physicians, the health officer, the parents, and the various community agencies determine to a great extent the success or failure of the health work in the schools. The way in which she discharges her responsibilities sets the pace for the whole program.

The supervisor can assist the nurse to make her work more effective in many ways. She and the nurse to-

gether may interview the principal of the school and discuss the health program—which has previously been jointly planned by the various departments interested in the health of the children*—and the methods by which it is to be carried out. The supervisor may also visit the district superintendent and ask for his coöperation. Very often, he will stress the health activities at a principals' meeting, and so promote an understanding of the program by the school authorities. The supervisor may encourage the nurse to speak on the

* See "The School Nurse Plans Her Program," by Ella E. McNeil, *PUBLIC HEALTH NURSING*, April 1940, p. 238.

health activities to teachers and parents at their group meetings.

TEACHER-NURSE CONFERENCE

Perhaps the most valuable aid in developing health consciousness and stimulating interest in the health work on the part of the teachers is the teacher-nurse conference. The supervisor may stimulate the nurse to develop the conference along mutually helpful lines since the discussion between the teacher and nurse offers such a splendid opportunity for interchange of information. The nurse interprets the physician's findings to the teacher and discusses the carrying out of his recommendations. She also discusses the pupil with the teacher, keeping the background and home conditions of the child in mind. The teacher should be informed of the progress the child is making in regard to needed treatment and correction of defects. The teacher in turn contributes much to the conference. She informs the nurse of what she has observed about the child. She reports the findings of vision tests which she may have made and the progress of dental work which children have had done.

The program for the handicapped child really begins during the teacher-nurse conference. It is followed up by the medical examination and the securing of adequate medical attention for the child. Here the supervisor will help the nurse to work with the family on a plan for the child. The parent is always invited to be present at the school medical examination, and preparations are made so that there is privacy for his conference with the school physician and nurse. The physician takes time to interpret to the parents the child's condition, and both nurse and doctor aid him in making a plan for treatment and for the correction, insofar as possible, of defects. During the period before a pupil can be placed in a

special class, the teacher and nurse plan to make the best adjustment possible in the classroom, such as placing children with vision and hearing defects in favorable seats.*

The below par child is carefully observed by the teacher and nurse, and after referral to the physician and conferences with the parents, the doctor's recommendations in regard to matters such as exercise and rest at school and at home are carried out. Children needing the care of the child guidance clinics are observed and referred for care.

The so-called normal child is not forgotten; sometimes he is the one who needs more guidance and help than the child with special problems. The teacher and nurse should be alert to the needs of each individual child. All the information secured is placed on the pupil's health card, which is a cumulative record of his health throughout his school life.

HELPING NURSE PLAN SCHEDULE

Another way in which the supervisor may aid the nurse is by helping her to plan her schedule to include adequate time in school for interviewing the parents and for home visiting. The conference between parent and nurse in school or home is an invaluable aid in the health program. Here, the parent may sit down and discuss his problem with the nurse without interruption. Many parents prefer to take advantage of the invitation to come to school to talk things over. However, school consultations can never entirely take the place of home visiting. Some mothers

* The proper seating of the child with a hearing impairment is discussed in "The Hard-of-Hearing Child in School," by Ena G. Macnutt, *PUBLIC HEALTH NURSING*, January 1939, page 47. Seating and other factors favorable to good eye health are discussed in "An Eye Health Program for All the Children," by Winifred Hathaway, *PUBLIC HEALTH NURSING*, April 1937, page 229.

and fathers are unable to come to the school. And very often the nurse wishes to obtain first-hand information about the home conditions. Here, again, the supervisor plays a part. She may help the nurse to make a wise selection of homes to be visited and of parents who may well be seen in the nurse's office.

Although the staff nurse herself is responsible for all these activities, the supervisor can be of assistance by making sure the nurse understands the program and is able to carry it out. The wise use of community resources can be encouraged by informing the nurse of the new facilities available and by helping her to make correct use of all the resources the community offers. The supervisor should make certain the nurse understands which things are her responsibility and which are the teacher's. The responsibility of the family for the child should also be fostered and encouraged by the nurse.

The supervisor will help the nurse to recognize the need for special tests—such as audiometer tests. Very often the equipment for such tests can be secured by the school if the nurse recommends that a large number of pupils seem to need such testing. The follow-up of

such tests, of course, depends on the best possible use of existing community resources and here the supervisor may aid the nurse to keep up to date. The coöperation of the parents is necessary to do adequate follow-up work.

In all her relationships with the school personnel, the supervisor of school nurses will remember that her aim is to strengthen and reinforce the influence of the nurse in the school and with the parents.

It is important in assisting the school nurse to do a better job to equip her with the most up-to-date scientific knowledge.

Activities in the school should be carried out by the school nurse, with the supervisor in the background to aid and advise. Much of this can be accomplished through individual conferences with the nurse, through frequent observation of her activities in various working situations, and by discussion and participation of the staff in group conferences.

Presented before the N.O.P.H.N. Round Table on Supervision in School Nursing, Biennial Convention, Philadelphia, Pennsylvania, May 16, 1940.

NURSE PLACEMENT SERVICE



announces the following placements from among appointments made in

the various fields of public health nursing. As is our custom, consent to publish these has been secured in each case from both nurse and employer.

*Grace Frauens, Director of Public Health Nursing, School of Nursing Education, Duquesne University, Pittsburgh, Pa.

*Irene Thompson, Director, Visiting Nurse Association, Santa Barbara, Calif.

*The N.O.P.H.N. files show that this nurse is a 1940 member.

*Louise Schafer, Educational Supervisor, King's Daughters Visiting Nurse Association, Norfolk, Va.

*Ruth Kooiker, Educational Supervisor, Visiting Nurse Association, Bridgeport, Conn.

*Helen Kienzle, Senior Counselor, W. K. Kellogg Foundation, Battle Creek, Mich.

*Ella Alethea Hunt, Supervisor, Visiting Nurse Association, Waterbury, Conn.

Elizabeth King, Supervising Nurse, American Viscose Corporation, Parkersburg, W. Va.

*Lucile M. Johnson, School Nurse, Pekin Community High School, Pekin, Ill.

Emma Arndt and Dorothy Lasch, Temporary Industrial Nurses, Mars, Incorporated, Chicago, Ill.

Mary Clare Sherburne, Staff Nurse, Visiting Nurse Service, Madison, Wis.

(Continued on page 538)



THE SCHOOL CHILD'S POSTURE

BY HALFORD HALLOCK, M.D.

*Photograph by Wendall MacRae
from Willingly to School, Round
Table Press, Inc., New York*

IT IS recognized that a relationship exists between good posture and good health and poor posture and poor health. The evidence also indicates that this association may be one of cause and effect.

Faulty posture is extremely common. It has been estimated that at least 75 percent of the youth of this country exhibit abnormal body mechanics. In the Chelsea, Massachusetts, Survey, conducted in 1923 and 1924 under the auspices of the Children's Bureau of the United States Department of Labor, 92 percent of 1708 public school children were found to have poor posture.¹ And in a health survey in the schools of Los Angeles in 1928, there were 35,000 who exhibited abnormal posture.² Eighty percent of 2200 students studied in 1923 at Yale and a similar percentage of Harvard freshmen examined in 1916

How are posture and health inter-related and how can a child be helped to achieve poise in the use of his body?

and 1919 exhibited poor body mechanics.³

Poor posture begins in childhood and usually persists into adult life. There is only a slight tendency for spontaneous improvement to occur. Ninety-nine percent of the Chelsea children in the age group of seven to under nine years had faulty posture as compared with 88 percent in the group of fourteen years and over. The figures from the college studies also support this fact and indicate that a little more improvement may take place between adolescence and maturity.

The picture of poor posture is well known, but the unfavorable effects of faulty body mechanics are usually not

appreciated. The child who has poor posture stands with a forwardly thrust head and neck, a flattened and depressed chest, a sagging and protuberant abdomen, and increased spinal curves. (Fig. 2 and Fig. 4.) The parts of the body are out of balance, and abnormal and unevenly distributed muscular effort is necessary to maintain the erect position. This causes muscular strain and chronic fatigue which exert an unfavorable effect upon the health and well-being of the child.

VITAL ORGANS HANDICAPPED

Faulty posture interferes with vital functions. The flattening and depression of the chest reduce the volume of the thoracic cavity and allow relaxation and sagging of the diaphragm. Complete expansion of the lungs does not take place, and as a result there is a decrease in the supply of oxygen for the body with consequent lowered resistance and endurance for the individual. The contractions of the diaphragm, in addition to effecting respiration, exert a powerful and beneficial pumping force upon the great thoracic and abdominal veins which return the blood from the extremities and viscera to the heart. In poor posture the diaphragmatic relaxation and sagging result in weakened and shallow movements, and the favorable pumping effect upon the veins is lost. The venous flow of blood is retarded, with resultant sluggishness of circulation and congestion in the visceral organs and limbs. The narrowing of the anteroposterior diameter of the chest affords the heart less room in which to relax and contract, and the lowered position of the diaphragm allows it to sag. This places excessive traction on its great vessels and controlling nerves which are supported in the upper thorax and neck, and further interferes with cardiac action.

The relaxation and sagging of the abdomen cause a ptosis or falling of the

abdominal organs. Malpositions and abnormal areas of pressure result, which impair function and promote congestion and which may be responsible for gastro-intestinal disturbances, constipation, and functional renal and pelvic disorders such as orthostatic albuminuria and dysmenorrhea in girls. Relaxation of the anterior abdominal muscles allows the symphysis pubis to drop and the pelvis to rotate backward. This produces the exaggerated forward curve of the lumbar spine or "hollow back" which is so typical of faulty posture. The joints of the spine are forced into extreme positions, and the result is chronic strain and susceptibility to injury.

POSTURE AFFECTS GENERAL HEALTH

Imperfect body mechanics have an unfavorable effect upon the efficiency of an individual and upon his incidence of illness. The Chelsea Survey and studies made in Maryland and Missouri indicate that posture training and the maintenance of good carriage contribute to the health and efficiency of normal elementary school children. School work showed improvement and lower rates of illness were found in the spring term among those children who had been trained in posture during the year.

From the esthetic point of view, poor posture is not desirable because it is unsightly and movements of the body are not easy or graceful. In addition, individuals with poor carriage give impressions of laziness, inefficiency, and lack of endurance.

HEALTH APPRAISAL FIRST STEP

Faulty body mechanics can be corrected, and improvement once gained is usually maintained. Before beginning any program of posture training, a careful medical examination should be made in order to discover any associated organic condition or structural defect that



Figure 1. Good posture



Figure 2. Bad posture

may be contributing to the abnormal carriage. Malnutrition and anemia must be considered in this respect as well as diseases or deformities of the muscles, bones, and joints; and appropriate treatment should be instituted before or during the posture training.

For instance, a child who is undernourished and anemic or who is exhausted from insufficient sleep simply does not have the requisite strength to maintain good posture. A short leg, a structural spinal curvature, a contracture of the hip flexor muscles following poliomyelitis, or a visual defect such as strabismus or nearsightedness will alter the position and use of the various parts of the body. Such conditions and defects must be corrected before any postural work can be effective.

Since abnormal posture begins and is more prevalent in childhood, and as our system of universal education requires that all children shall attend school, it seems only logical that the chief attack upon the entire problem of body mechanics should be made during the

school-year period. Training in posture at this time is more effective, because faulty attitudes are more easily corrected in childhood. Children are more amenable to instruction, their bodies are more pliable, and the abnormal positions have not existed for so long. Posture training is an important aid in the development of physical and mental health and fully justifies its inclusion in the curriculum of the modern school.

WHAT IS GOOD POSTURE?

Training in posture should always begin with instruction in the fundamentals and desirability of good body mechanics. Little progress will be made if the child does not know what is good posture and why it is important.

The Subcommittee on Orthopedics and Body Mechanics of the White House Conference on Child Health and Protection considers that if the spinal curves which are associated with the habitual posture of the individual are not so extreme as to threaten or produce joint and muscle strain and disturbance

of visceral relations, and if the posture is such that there still remains a margin of safety which allows more mobility in all directions, the spinal curves and the weight-bearing lines of the lower extremities may be said to fall within normal limits for the individual under consideration.

The specific requirements for good posture, irrespective of whether the child belongs to the slender or stocky type of body build, are given by the Committee as follows:

1. The head is held up with the chin in, and is balanced above the shoulders, hips, and ankles.

2. The thorax with the head held as in 1., and with the abdomen drawn in is maintained in such a position that the breast bone or sternum is that part of the body farthest forward.

3. The lower abdomen is held "in and flat."

4. The curves of the back are maintained within normal limits.

In such a position, the body is in balance; and less muscular effort is required to remain erect and to make movements. (Fig. 1 and Fig. 3.) Economy of effort is secured, which prevents fatigue and strain and conserves energy. The volume of the thoracic cavity is restored to normal, and expansion of the lungs and action of the heart and diaphragm are unimpaired. The firm, flat abdominal wall supports the viscera and prevents harmful displacements. The spinal joints are protected from strain because normal curves are maintained and margins of safety motion are assured.

The person with good posture has a pleasing appearance. He moves easily and gracefully, creating the impression of energy, efficiency, and vitality.

MOTIVATE THE CHILD

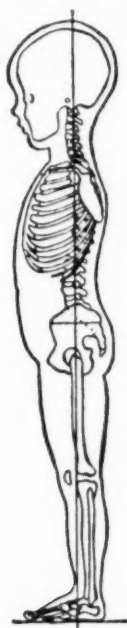
In order to motivate the child to have good posture, it is advisable to stress the better appearance and attrac-

tiveness of proper posture, and the increased strength and endurance of good body mechanics. It can be emphasized that good posture means more enjoyable social life and increased prowess on the athletic field. Individual records of improvement and achievement in good posture and rewards or honorable mention in recognition of efforts toward improvement of body mechanics may be effective in stimulating further interest. Varied exercises performed in groups and to the accompaniment of music arouse more interest than perfunctory calisthenics in the aisles between school desks.

After the child has come to a realization of the desirability of good posture and thoroughly understands what constitutes good carriage, he is given daily training in postural exercises and games in order to strengthen and gain voluntary control over requisite muscle groups and to enable him to assume good posture. He must then be encouraged to persist in these and in the daily practice of sitting, standing, and moving always with good posture until good body mechanics have become a habit.

This means that whatever the child is doing, be it in the classroom, on the playground, or at home, he should constantly hold his body with the abdomen and chin held in. When studying, he should sit erect in a chair with a well fitting back and with a seat that is no longer than the length of the back of his thighs. When leaning forward to write or draw, he should bend at the hips, keeping the spine erect and not allowing the shoulders, chest, and upper spine to slump downward and forward. The desk which holds his book or paper should be at such a height that reading and writing in the erect position is comfortable and easy.

The correction of faulty mechanics is accomplished by instruction in the fundamentals of good body mechanics and daily training in postural exercises.



Left: Figure 3.
Skeleton of a child
with good posture



Right: Figure 4.
Skeleton of a child
with bad posture

Games that are concerned with the posture of the body and games that strengthen different groups of body muscles should be used to maintain interest. These include all kinds of running games and sports such as soccer, basketball, tennis, handball, and swimming. Work on the flying rings in the gymnasium is valuable because it extends the body. Marching and dancing are excellent forms of posture-developing activity.

Many sets of formal posture exercises have been devised. An excellent group is described in *Posture Exercises*, a publication of the United States Children's Bureau.⁴

"SIT AND STAND TALL"

On the playground and at home, the child should constantly "sit and stand tall." Sitting on the end of the spine with the buttocks near the front edge of the chair or standing and sitting in a slouched position so that the body assumes the shape of an exaggerated question mark are to be assiduously avoided.

Clothing should be no heavier than the exigencies of the climate demand as too much weight on the shoulders and chest causes sagging and drooping of the upper part of the body. During the hours of rest and sleep, the child should lie in an extended position upon a firm hair or felt mattress supported on springs that are sufficiently strong to prevent undue sagging. Further support can be obtained if needed by placing a three-ply board between the mattress and the springs. Preferably a pillow should not be used, but if something soft is required beneath the head, a thin pillow of small size is permissible.

No amount of effort is too great to devote to the attainment of good posture; for in the words of Dr. Joel E. Goldthwait, the most authoritative exponent of good body mechanics, "to stand erect, to walk or move easily, to have the various parts of the body so perfectly adjusted that easy balance and graceful use must result, is to be desired for reasons of far greater importance than the esthetic. Such elements are of

absolute importance for perfect health and the fullest economic efficiency, since the use of the body in proper poise insures the least friction with consequently the greatest amount of energy available for what may be required of the individual."⁵

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(Continued from page 532)

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During early September when this issue appears, there will in all likelihood be some very urgent and last minute requests for qualified school nurses. The demand will then be at low tide until the following spring when school nurses may or may not renew their contracts for fall appointment. Nurses interested in this special field will appreciate the advisability of getting their professional biographies in

readiness for referral well in advance of the date they may be able to report for duty. The same necessity applies quite generally to all fields. The confidential professional references secured from employers and schools are sometimes very slow in coming to the agencies handling the nurses' applications. Also, after negotiations have been established between nurse and employer they are often retarded because superintendents of schools, and nurses, too, may be away for study or vacation.

For practically every school position, employers are today requesting nurses with the full year approved program of university study in public health nursing. For the better salaried positions they also are demanding a college degree. School nurses wishing employment during the summer may find pleasant situations doing camp nursing during the months of July and August. Registration early in the spring for camp work is advisable as positions are listed beginning in April for filling usually on July 1.

ANNA L. TITTMAN, R.N.
Executive Director

The Nurse's Child Health Conference

By LAURA S. STORY, R.N.

The nurse's conference sessions for instruction and interpretation to parents have become an important part of the child health service in New York City

NURSE conference sessions in the child health stations of the New York City Department of Health developed from an attempt to give a more adequate and individualized service to mothers who utilize the stations for health supervision of their infants or preschool children. The physicians became interested in this part of the nursing service first as a device to relieve the medical conference sessions and to allow for more detailed medical instruction and advice than was possible in the larger conferences. They began using the nurse conferences as a means of lengthening the interval between appointments at the medical conferences.

The mothers are asked to come in and see the nurse about those things which can be done without a physician's presence, such as increasing formulas, starting new foods, and observing the child's progress closely. In each case the physician at the medical conference writes definite orders as to what is to be done at a specified time and tells the mother that the nurse will instruct her in the matter when she comes to the nurse conference. The nurse's responsibility is to relay these orders accurately and give the proper instruction for carrying them out and to observe the infant or child closely for any sign of a condition which would warrant medical attention. Such children are brought in at once to see the doctor. The following procedures have been adopted for nurse conference sessions:

The number of mothers coming to the

nurse conference sessions is limited to eight or ten per nurse for a session of three hours. They are given definite appointments for the date and the time. The appointment system is maintained as strictly as that for the medical conference session with two exceptions. If a mother comes in without an appointment when a specific need is present, she is seen by the nurse, who fits her into the program. Otherwise she is given an appointment for another nurse's conference or a doctor's conference as indicated, and the appointment system is explained to her. Mothers who fail to keep their appointments are sent post card appointments for future dates unless they are scheduled to come in to see the doctor soon.

WHO ATTENDS NURSE CONFERENCES?

The mothers to be given appointments for the nurse conference session are selected on the basis of needs. Besides those referred by the doctor for interpretation of orders and closer observation, mothers needing greater help in understanding their instructions and their problems and mothers of preschool children are among this selected group. Both doctor and nurse refer to the nurse conference those mothers requiring more assistance than can be given during the medical conference. The mother is referred to the nurse conference, for example, when a social or home problem is presented which she seems incapable of solving by herself; when she does not seem to grasp the directions given her or



Photo by Maurice L. Levy

Learning the easiest method of baby care

their importance; when her ability to carry out such directions is questionable; when she seems to have an inadequate knowledge of infant or child care and evinces helplessness in her handling of the child; when she displays undesirable emotional attitudes and reactions in her management of the child; when behavior problems or the physical condition of the child indicates the need for close follow-up.

The mothers of preschool children come in at stated intervals between visits to the doctor. This age group does not require as frequent medical attention as the younger group, and contact with the station may be broken completely without a plan for continuity of service. Since it is during the preschool period that behavior patterns are being formed, it is essential that these children receive close observation and attention and that the mothers receive adequate assistance with the problems presented. It is believed that the nurse can meet these needs by giving the mothers guidance in child care, helping to relieve their anxieties, and bringing

to the doctor's attention those children who need medical care.

PROCEDURES OF NURSE CONFERENCE

To free the nurse for her conferences, the clerk receives the mother when she comes to the conference session and takes her in to the nurse at the appointed time. The nurse then weighs the child and has her conference with the mother. In order to make this an effective teaching situation, sufficient time is allowed so that neither the mother nor the nurse feels hurried and both are at ease. Privacy is provided so that the mother will feel free to discuss with the nurse any problem she may have. Care is taken to make the mother comfortable and to prevent interruptions. Equipment is placed conveniently near so that the nurse can give demonstrations if needed, and appropriate literature is at hand. The names and addresses of available agencies for child care and forms used for referring mothers are kept within easy reach. At the end of the conference, the mother is reminded of her next appointment with the doctor or given an earlier one, and the importance of keeping it is re-emphasized.

RECORDING OF THE CONFERENCE

During and after each conference the nurse records all pertinent data on the child's chart. These include the matters taken up with the mother; the results of the discussion, such as plans for solving the mother's problem or for carrying out the doctor's orders; the instructions given by the nurse; the progress made by the child, and any physical conditions or behavior symptoms noted by the nurse. In fact, anything related to the child's welfare is on the chart so that the doctor and nurse at the next medical conference session can have the advantage of this information.

The supervisor can assist the nurse in her efforts to achieve productive nurse

conference sessions, in many ways. The supervisor can give her assistance when demands for the conference become greater than she can manage, by helping her to reorganize her work so that more time is available, and by giving her additional personnel so that more mothers can be seen at a session. The supervisor can help the nurse develop her powers of observation, by pointing out the various emotional, mental, social, and physical factors to be noted; those signs and symptoms indicating the need for help; how to evaluate what she observes in the mother's handling of the child or the child's behavior; and the way in which the attitudes and reactions of the mother and child may be interpreted.

The supervisor can aid the nurse in gaining a greater knowledge of child health by making available appropriate books and other materials on child health and child guidance, and by stimulating her to further reading. This is important since theories and emphases change quite radically due to the results of new research in regard to the physical and psychological aspects of life.

Another factor is the huge amount of information on child health matters that mothers receive through the media of radios, papers, magazine articles, lay meetings, and advertising. The nurse is often called upon to interpret information received through these various channels and must be prepared to sift the true from the false and to correct erroneous ideas picked up in this fashion.

The supervisor can demonstrate that in an interview it is not enough to put the mother at ease and to build up a friendly relationship, but that the nurse must also be able to draw the mother out; to let her talk and to listen to her in order to discover her needs and problems; to show interest in the mother's search for help by answering all direct questions.

The supervisor can make the nurse aware of teaching situations and the



Photo by Maurice L. Levy

I can sit by myself

possibilities inherent in them when they are recognized and utilized, as well as the value of individualizing her teaching methods so that they are adapted to the mother with whom she is dealing and so that she builds upon what the mother already knows and understands. The supervisor can advise her against the dangers of an autocratic or dictatorial type of instruction and show the need for explaining to the mother the reasons underlying her instruction and suggestions. The supervisor can make her appreciate the importance of having the mother and her wants the center of interest rather than what the nurse wishes to impart, and of using simple language and terms familiar and meaningful to the mother herself.

These are but a few of the ways in which the supervisor can give guidance to the nurses in their conference work. That such guidance is effective has been proved by the work done by nurses in their conferences with mothers coming to the child health stations and the results obtained from these conferences.

Not the least important of these results lies in the realization by the nurses of how much help and guidance they themselves can actually give mothers in child care.

INTEGRATION OF ENTIRE PROGRAM

The nurse conference session is coordinated with the entire child health program of the health department. Its services are utilized by nurses connected with other parts of the program as well as by the doctors and nurses at the health stations. On the other hand, the nurse who conducts the nurse conference avails herself of the benefits to be derived from these other activities in helping the mother with problems.

Mothers are referred to the nurse conference session by the nurse holding mothers' classes when she recognizes the need for more individual instruction than a class can provide. The mothers themselves will request an appointment to a nurse conference when they become aware of inadequate knowledge through the class discussion or when they desire to take up questions which they do not wish to discuss at a group meeting. During a nurse conference session, if the nurse discovers that group instruction is sufficient to give the mother the necessary understanding in child care, she recommends and helps arrange for admission to mothers' classes. She explains their value and the necessity for regular attendance during the entire series.

Progress is being made in the plan for complete generalization of the health department nursing service. The majority of the districts are now generalized but there are some that are still specialized. In the specialized districts the child health conference nurse makes her own home visits and is assisted as needed by the field nurses in all child health activities carried on in the health center. In the generalized districts there is a partially generalized nursing service. To provide for continuity of service

and efficiency, the clinic nurses are assigned to the health centers for full-time duty since there are morning, afternoon, and evening sessions in some of the services. Therefore, the clinic nurses have to depend upon the field nurses for the home visits made to their patients. The field nurses serve in the schools, assist in the different clinics as needed, and visit all types of patients in the home. The generalized philosophy and point of view is maintained since all the nurses are rotated through the various services. They are assigned to them for a period of from six months to two years, and they receive instruction in all the nursing services given by the health department.

DOES CONFERENCE REPLACE VISITS?

When the family and home conditions are known to the nurse at the health conference, a home visit is not always essential to meet a particular problem. By using the nurse conference session for these mothers, more can be seen by the nurse than if they were visited in the home. Where home and family conditions are not known by the health conference personnel or where further care and observation in the home are indicated, a home visit is made by the field nurse of the district in which the mother resides. This need is often brought to light during the nurse's interview with the mother at the nurse conference session and a home visit is requested. The nurse prepares the mother for the field nurse's visit by explaining its purpose.

The conference nurse outlines in a written report to the field nurse the physician's plan for the child; what progress has been made in carrying out this plan; what information is needed from the home; and what further instruction to the family is necessary. The requested information, results of the visit, and all pertinent data relating to the home and family conditions are

returned to the health conference by the field nurse and incorporated on the child's chart for the benefit of the conference personnel in helping the family with future plans for the child.

The field nurse in making her visits in a generalized program considers each individual member of the family. When she finds mothers with infants or preschool children in homes where the parents' knowledge of child care is limited, she suggests attendance at a mothers' conference session for more detailed guidance. She points out the advantages to the mother and obtains an appointment for her from the conference nurse. If the child is not already under medical supervision arrangements are made for such care, since the nurse conference supplements but does not replace in any way a doctor's supervision. When the child is under medical supervision, however, the nurse conference with the mother is sufficient in most cases.

Excellent coöperation between the field nurse and the child health conference is obtained in this way, which results in better care for the child. The field and conference nurses collaborate in helping the family work out a practical plan to meet their needs and the doctor is able to adjust his treatment of the child to meet the various problems presented.

THE FAMILY AS A UNIT OF SERVICE

The family is considered the unit of service and the infant's or child's care is fitted into the total needs of the family. At the nurse conference session, the mother is encouraged to tell the nurse any problems connected with the home, since such problems are related to the health and well-being of the child. An opportunity is given the mother to tell her troubles so that a knowledge of family relationships and difficulties is presented to the nurse. In advising the mother, these are taken into considera-



Photo by Maurice L. Levy

The most approved styles in infant wear

tion, not only as they affect the child's health, but in helping the family formulate a plan that will meet the requirements of the other members as well.

The nurse finds out whether another member of the family attends one of our other clinics or is known to the school nurse. If this is the case, the conference nurse will consult with the nurse of the clinic or school to augment her knowledge of the family; to learn of plans they have helped the family make; and to correlate her work with the other services given to the family. This makes for integration of such services and eliminates the danger of overemphasizing one problem to the detriment of others. The benefit of the combined knowledge and resources of the nurses involved is thus given to the family.

A worried or overburdened mother seldom gives the best care to her child, and everything is done to prevent this condition whether the problem is presented by the child or another member of the family. When services not provided by the health department are required, or when it is necessary to rectify a difficult condition in the home, the mother is referred to an agency that will enable her to secure the necessary service.

Where a serious family problem is brought to light, the family is cleared through the social service exchange and referred to the proper social agency. The nurse will make available to the social worker what she knows about the family and will work closely with her in helping the family with the problems. The two consult with each other and the nurse in her contacts with the mother at the child health conference will help the mother to understand the value of using the social worker's guidance and help.

In these various ways, the total family situation is provided for and the infant's or child's treatment is adjusted to family conditions. To insure a complete family service, a home visit is always made when the conference nurse has any question regarding the family situation. This emphasis on the family in the child health program is made so that anything done for the child will assist in promoting the family health and welfare. Also, the omission of other individuals in the household from consideration will result in less efficient care for the child, since a breakdown of the general family health and morale will cause suffering to any individual member of the family.

LEARNING TO WALK



ROSEMARY, who has cerebral palsy, is now learning to stand, balance, and walk with the aid of the walker pictured here. For the past year she has been at home and is steadily improving and gaining confidence.

Her happiness in her growing independence is a delight to her parents and to the school nurse, Phyllis G. Orsatti, Colorado Springs, Colorado.

The Rural Nurse and Program Planning

BY LILLIAN K. MEADE, R.N., AND MARY JANE LEAKE, R.N.

"Where shall I begin?" asks the new nurse in a rural area. These suggestions are applicable to the nurse working alone or in a health unit, without nursing supervision

FIVE HUNDRED dollars for knowing where to tap! The story is told of a man who succeeded, after many others had failed, in repairing machinery for a manufacturing concern. He presented his bill, five dollars for tapping, five hundred dollars for knowing where to tap.

This ability to know "where to tap" is the valuable commodity which the nurse brings to the community to help it develop its public health work. Such ability comes from adequate preparation through months of practice in a well established public health nursing organization and theory in general public health procedure.

The rural nurse faces the challenge of helping to mould the health attitudes and practices of the community she is to serve. In this age of publicity, even the community inexperienced in public health organization has its ideas of what it expects of the local health department and the new public health nurse. Tact, understanding, skill, and enthusiasm will be required of every worker if the people are to achieve what the nation has been led to expect from public health work—prevention of disease, prolonging of life, and promotion of physical and mental efficiency of the individual.*

INTRODUCTION TO THE STATE FIELD

Since a first-hand knowledge of the functions and facilities of other health and welfare agencies is invaluable to the

nurse, many state health departments are providing an observation period for each new rural nurse at the beginning of her service. Included in this introduction are field trips to organizations interested in the deaf, blind, tuberculous, crippled, and other special groups. The nurse will find this an interesting experience, and will draw on it many times in the future.

ADMINISTRATIVE RESPONSIBILITIES

If the nurse enters a full-time health unit, the primary responsibility for determining the policies, procedures, and program of services will rest with the medical director of the unit, who will presumably expect helpful participation from her in plans which affect her work. If the nurse is working without the direction of a full-time health officer she will have to assume more responsibility in program planning. The suggestions made here are particularly for the nurse working without nursing supervision or without a medical director. However, the general principles of program planning are applicable, whatever the administrative setup.

INTRODUCTION TO THE LOCAL FIELD

It will be an advantage to the nurse in a new territory if she is expected to use the first three or four weeks for orientation and study of the community situation. The group of local persons whose efforts made the new public health service possible will be anxious to know the personnel and will help the nurse to

*Adapted from a definition by Dr. C.-E. A. Winslow.

become acquainted with the people and problems.

Among the first things, the nurse will want to meet the physicians, dentists, county officials, local health and social workers, and other community leaders. If she is a good listener during these visits, she will glean a great deal of information about local interests and health problems. The beginning of a case load should also result. These visits also provide an opportunity to explain the aims and policies of the nursing service.

If the nurse has a genuine liking for people and a dash of adventure in her make-up, she will find the strenuous task of meeting one physician and community leader after another stimulating and thought provoking. Just as it is characteristic for rural folk to look out from behind curtained windows and gaze at the stranger or note that the village doctor is going north with the Jones child in his car, so are they interested (and we don't mean maliciously curious) to know about the new nurse. They want to know what she is like, where she is from, and what she has been doing. One young rural nurse expressed herself as she emerged from the local newspaper office: "Well, I feel as if I had died and released my own obituary."

EARLY PROBLEMS

In some communities the nurse working alone is expected to make a number of important decisions before she has become oriented. Such a relatively insignificant item as selecting office quarters may lead to a bad headache later. When there is no obvious space for the nurse in the courthouse or civic building, a health-minded superintendent of schools or an interested county agent or welfare worker may suggest that the nurse share office space with him. This is usually to be avoided. The close association with an agency which itself

may not be strong may weaken the service; if strong, it may tend to overshadow the new nursing service.

The same pitfall is to be avoided in a too early selection of living quarters. Even though the nurse feels that the rates are prohibitive, she will not regret later that she stayed at the town's hotel until she was sure of making an intelligent choice.

OFFICE AND EQUIPMENT

The selection of suitable office space for the nurse and the provision of equipment that is adequate to carry on good work are the responsibility of the medical director in the health department or of the sponsoring lay group. Most state public health nursing manuals have a list of suggested equipment and supplies for the nurse. It is unfair to expect a nurse to do a good job without necessary facilities. The nurse should discuss with the organization at the onset what equipment and facilities are adequate. If they are not immediately available, ways and means should be devised for procuring them in the not-to-far-distant future.

In addition to the office and nursing equipment, the following information should be readily accessible for use:

Local

Health laws of the county and cities in the territory

Vital statistics

Morbidity statistics

State*

Health laws

Vital statistics

Board of health annual report

Public health manual

National**

Vital statistics

Invaluable to the nursing service, also, are approved reference books on (1) communicable diseases, including tuberculosis and syphilis and gonorrhea

*Secure from the state department of health.

**Secure from the Bureau of the Census, Washington, D.C.

(2) maternal and child health (3) nutrition (4) orthopedics (5) teaching methods and materials (6) mental hygiene (7) public health practice. With her professional nursing magazines, the materials accumulated at the university, and the use of state and national libraries, sources of dependable information will be available whenever needed. Local libraries in rural areas are not likely to contain much reliable reference material. Correction of this lack is usually not a difficult task and is an integral part of the public health program.

MEDICAL ADVISORY COMMITTEE

The success of the health program depends to such a tremendous extent upon the coöperation and good will of the local physicians that their counsel should surely be sought in program formation. This can best be accomplished through the use of a medical advisory committee. The committee may be appointed by the local medical society soon after the organization of the health service. It is no easy task to keep this group functioning, but the results are worth the effort expended. The function of the group is to consider medical problems and programs, to determine policies and procedures involving medical care, and to interpret the service to the medical society. Suggested nursing procedures (sometimes called standing orders) are referred to them for review before being presented to the medical society for approval.

Physicians should be able to voice objections and make suggestions to the committee. This provides for bringing into the open objections which might otherwise smoulder. It is better to scrap a seemingly important item in the program than to include it against the wishes of the medical group.

Regardless of qualifications and enthusiasm, the rural public health nurse cannot hope to do a successful job alone. Only when community people feel that

the program is theirs will they support it successfully. A lay committee is a tower of strength before the appropriating bodies. A countywide group of leaders who are informed and are working with the nurse is in a strategic position to interpret and sell health work to their neighbors. Innumerable tasks that will have to be done if the work is to progress can very well be done by lay workers. If there is no one but the nurse to taxi a child to the doctor or hospital, to arrange for space for a mothers' class, or to gather up equipment for exhibits, she will be so entangled in details that she will never emerge from them.

CITIZENS' ADVISORY COMMITTEE

The community should feel the need for a public health committee before one is formally organized. This does not mean that the health service need wait the weeks or months before making use of the community assistance available. Mention was made above of the group of local persons whose efforts made the new public health service possible. A health service comes into being because some people within the area *wanted* such a service. Starting with this group as a nucleus, and growing as others become interested in community needs, a public health committee comes into existence—a committee which, like the newborn infant, needs constant care and nurturing but is very much worth all the effort one may put into it.

THE CONSULTANT NURSE

If the regular assistance of a supervisory nurse is not available, full advantage should be taken of the consultant service which state health departments provide. In situations where the consultant nurse can direct the work of the less experienced nurse for at least half of the first month and at frequent intervals thereafter, the probability of developing a sound public health nursing

program will be materially increased.

With preparations for the new service made in harmony with the community resources, the nurse applies herself to the *what, why, and how* of a program. With only one nurse where five should be, what nursing services shall be offered? On what grounds shall she base her selection? What methods shall she use to produce lasting results?

A COMMUNITY SURVEY

It is wisdom, in any undertaking, to study both past experiences and the present lay of the land. The new health service may profitably take time to learn the community history and resources before calculating its need. The survey outline given in the Appraisal Form for Local Health Work* may be used as a guide for this analysis, which is undertaken by the group sponsoring the health service with the help of the nurse. The previously mentioned visits to physicians, dentists, hospitals, school administrators, social organizations, and county officials may be utilized in obtaining information for the survey.

Facts obtained may be used also as items of public interest in personal interviews, newspaper releases, and group talks. What is happening at home is always more interesting than what occurs across the line.

PROGRAM PLANNING

In the actual program planning two factors are combined—what is learned from the survey, and public health science.

Maternal and infant health

Experience and evaluation of earlier programs in public health nursing have taught us that in directing our efforts toward good maternal and infant care, we are doing the most in bettering the health of the general population. The

care which babies receive during the first month of life determines largely their health status during the first year. The mother's breast milk may be maintained or lost these first few weeks. Nutrition standards and good health habits which will have a lasting influence on the welfare of the whole family may be taught. This service would, of course, have been started during the mother's pregnancy.

The nurse will want to plan a fair share of her time for maternity and infant service, but at best she can carry only a fraction of the cases. Community resources and customs will determine her selection, including factors such as the percentage of primiparous deliveries, the amount of antepartum care given, how early antepartum care is sought, the percentages of hospital and home deliveries, the amount of private duty nursing used in home deliveries, the quality of postpartum care, the facilities for the care of premature infants, and the customs of the community regarding infant hygiene.

In most communities where health service is new, there is still much reticence regarding pregnancy and the nurse must be ingenious in creating a demand for this service. The patient's physician, social agencies, and visits to families having preschool-age children will be the chief sources for securing patients until the service becomes better known. Birth announcements in the newspapers and birth registrations are also sources for infant calls.

School health service

The generalized public health nurse must have her school program well outlined before attempting to put it into practice. It should be planned with the assistance of the school personnel. Many public health administrators prefer to start new rural nursing service during the summer months in order to give more time to promoting good maternal,

*Committee on Administrative Practice, American Public Health Association, 1938.

infant, and preschool programs, and to planning the school service.

Since teacher-training institutions have been offering more health education courses, the teachers have assumed responsibilities once relegated to the nurse. Nurses now serve teachers best in a consultation capacity by visiting families in the homes, and by interpreting home conditions to the teachers.

Communicable disease control

Many communicable diseases which have been largely eradicated in cities are still problems in much of the rural area. The keynote in communicable disease control is, of course, prevention. Prevention by immunization and general education is a part of the infant and preschool health program. Public health nursing considers also the aspect of prevention through isolation of the patient from the community and from other members of the family. In the school service the early exclusion of the sick child and readmission of the recovered child help to safeguard well children.

The amount of tuberculosis work the nurse will plan to do depends upon the extent of the problem in the area. The incidence will probably be determined by the number of deaths, since the reporting of cases may be poor. The isolation of open tuberculosis, the discovery and treatment of patients with early cases, and a healthful environment for those exposed to the infection are the important factors in controlling tuberculosis.

The eradication of syphilis and gonorrhea is being stressed throughout the country. The generalized public health nurse should be thoroughly familiar with all phases of the program in her state and know to what extent it is being applied in the local area. If local statistics show few cases, lack of education and not lack of the disease is probably the reason. Education may be directed toward the individual and the

group. The nurse is in a strategic position to influence attitudes and promote preventive and treatment facilities.

Crippled children

The care of crippled children is also receiving national and state attention at this time. Here, again, the local nurse should know how this activity is being handled in the state and fit her work into that program.

Adult education

In her family visiting and group teaching programs, the nurse includes many subjects in the adult education field—cancer, heart disease, pneumonia, and others.

ONE NURSE PLANS HER PROGRAM

One nurse, starting a new service in a county of 20,000, found that the executive committee of the county tuberculosis association had sponsored the establishment of a public health nursing service through a county appropriation. The county is located in an area of high tuberculosis mortality, and the committee was interested in tuberculosis work.

With the help of the district health department, of which the nurse was a part, she made a survey of known tuberculosis cases in the county. As often occurs, it was found that more was known about tuberculosis deaths than about living diagnosed patients. The health department then interested the association in promoting a program to make existing diagnostic facilities available to the people. A medical advisory committee was formed to aid in this. After a program satisfactory to the association, the physicians, and the health department was worked out, the committee enlisted the help of the high-school teachers in educating the public to make use of the diagnostic methods. The doctors reported that sanatorium care was not available to patients in need of it, and the committee started work on a bill for state appropriation for

a tuberculosis sanatorium—a bill which had failed many times. It was passed by the legislature at the next session.

The maternity service was planned so that the nurse could give antepartum instruction to some mothers in each section of the county, and to all mothers known through the tuberculosis program. Postpartum nursing care included the demonstration of nursing procedures to a responsible member of the household. Supervision was continued for the infant. The nurse interested the Red Cross chapter in having a nurse with public health experience give classes in home hygiene and care of the sick, with emphasis on maternal and child care.

Parent-teacher associations were inspired to include infant and preschool children in their summer round-up programs.

The incidence of diphtheria and scarlet fever was high in the county. Much time was needed to teach the mothers nursing care of their sick children, to trace the spread of the diseases in the neighborhood and in the schools, and to refer suspected cases to the doctors.

The nurse assisted the state crippled children's service* by seeing that the crippled children of the county were brought under care.

School work for this nurse was necessarily limited to helping the teachers with their communicable disease problems, helping them to recognize physical defects and promote good health habits, and assisting with some physical examinations. She supplemented her own efforts by making available to the schools the help of other agencies—the school health consultation service of the state tuberculosis association; the visual education service, dental facilities, and nutrition consultation service of the state department of health; and the sanita-

tion service of the district health department.

By the close of this nurse's second year of work, the committee realized the extent of the need and took steps to procure appropriations for an additional nurse. Much is waiting to be done—in maternity, in syphilis and gonorrhea, in nutrition, in lay organization—but an intelligent and interested nurse has started a good service.

THIS PROBLEM OF BEDSIDE CARE

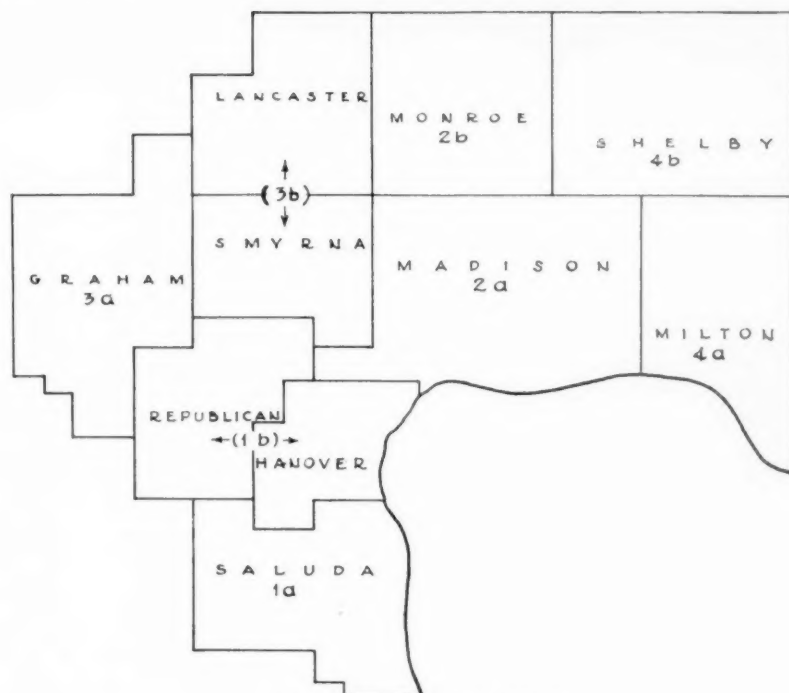
County nurses serving a large population agree among themselves that the inclusion of bedside care makes program planning difficult. However, they believe that every generalized program should be flexible enough to allow time for giving emergency care to patients and for demonstrating nursing procedures. Likewise, it is well for any county nurse to assist a physician with a home delivery now and then to check up on the practicability of her antepartum instruction to the same mother. The time is probably coming when there will be home delivery nursing service in all of our rural areas.

The nurse who is new to the clerical system as well as to the community will need to spend a little extra time in making records and reports. Accuracy and completeness are most important. The inexperienced nurse can only take the advice of others that good records are essential. A little later when she attempts to account to the community for her stewardship, as well as to evaluate her program, she will discover for herself their worth.

SERVING THE WHOLE COUNTY

Despite the fact that one nurse serving from 10,000 to 20,000 people cannot do a job adequate to meet the need, it is important that all sections of the county receive service. The following method of scheduling time and districts has been found effective in one area:

*In Indiana the Crippled Children's Service is carried by the State Department of Public Welfare.



Map of a county divided into districts

SCHEDULE FOR JULY 1940

Mon.	Tues.	Wed.	Thur.	Fri.	Sat.
Dist.	Dist.	Dist.	Dist.	Dist.	Dist.
1st Saluda 1-a	2nd Madison 2-a	3rd Open	4th Holiday	5th Milton 4-a	6th Office
8th Rep. and Hanover 1-b	9th Monroe 2-b	10th Open	11th Smyrna and Lancaster 3-b	12th Shelby 4-b	13th Office
15th Saluda 1-a	16th Madison 2-a	17th Open	18th Graham 3-a	19th Milton 4-a	20th Office
22nd Rep. and Hanover 1-b	23rd Monroe 2-b	24th Open	25th Smyrna and Lancaster 3-b	26th Shelby 4-b	27th Office
29th Open	30th Open	31st Open			

The same schedule is applied to August, September, October, and so on. With the use of a calendar or a file card system, this schedule may be used in dating calls ahead for any desired length of time.

"Open days" are included to provide flexibility in the schedule for such activities as physical examinations, clinics, meetings, and emergencies. Where they occur on a regularly scheduled day the routine work may be transferred to an open day.

PLANNING FOR HERSELF

While our public health nurse is keeping her hand on the pulse of her people, while she is *giving* daily of the fund of knowledge and understanding which she possesses, let us consider the nurse herself. Away from the stimulating discussion of others in her own profession, miles from the university, where does she turn for a replenishing of the fires of her enthusiasm, for the answer to the puzzling question, for additional learning in the advancing science of public health? The medical director will assist somewhat with these problems, but he too is a busy person.

The rural nurse in her program planning must include a plan for her own professional growth. The following suggestions are offered: Invite the consultants in every field to visit the service as frequently as possible. Part of their work is keeping abreast with the latest thought in their specialty and the nurse can learn much from them. Read nursing and public health and hygiene magazines. Get on the mailing list of some of the free or inexpensive approved publications. After becoming settled in the community and work, investigate to see what is given in university extension

courses in the vicinity. Some areas have public health associations to which workers within a radius of perhaps seventy-five miles belong. These provide both professional and social growth.

In summary, a public health nurse tackling a new job in a rural area needs knowledge, stability, enthusiasm, and guidance.

She needs, if possible, to be a part of a full-time health department.

She must have adequate working equipment.

Essential to her work is the support of the medical group and a responsible lay group.

A period of orientation is important—a time for the community and the nurse to become acquainted with each other, a time to survey the resources and to study the needs of the community.

She will consider what service it is possible for her to give and how her limited service may be supplemented.

She will endeavor to serve the whole county, distributing her time as intelligently and profitably as possible.

She will consider quality above quantity in work, and through the use of good records will be able to evaluate the tangible results of her efforts.

She will continuously influence her people to obtain for themselves public health service adequate to their needs.

While serving her people and her organization she will provide for her own professional growth.

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Health at a Women's College

By JANE FOSTER, R.N.

The public health nurse at Smith College has a threefold program which includes activities in the nursery school, with the students, and with employees

BEGINNING in 1932, Smith College employed a nurse who was neither to be in the infirmary caring for sick students, nor in the outpatient physicians' office as an office nurse. In the college catalogue she is listed as *public health nurse*, and no better title has appeared in the intervening years. Her actual work has changed and expanded during that time, but it has largely centered around activities in the nursery school, an employees' program, and work with the students themselves.

Smith College in Northampton, Massachusetts, is the largest institution for higher learning for women in the world. There are over 2000 students, a resident staff of over 250 cooks and maids, and 250 men working in the maintenance plants and on the grounds. A nursery school and a primary school are operated by the college. In addition there is the teaching faculty and a corps of administrative and secretarial personnel. This comprises, in substance, a small town, which is a rather specialized community with a concentration of individuals in the age group between 17 and 22 years. The nurse not only carries out the functions of a visiting nurse in the dormitories, but in her work with communicable disease, sanitation, and other environmental factors, takes on some of the jobs of a health department. In a college community, even more than elsewhere, she gives emphasis to the teaching function, and inter-

prets as far as possible all public health work.

Fortunately she does not have the whole job of health supervision. The town of Northampton has a health department, and in addition state health officials have served in a consultant capacity and have visited the campus more than once. The local secretary of the Massachusetts Tuberculosis Association has helped arrange routine x-raying of employees. The college has its own medical director and a corps of physicians. It has a hygiene department headed by a physician with two assistants as instructors; a part-time psychiatrist; an infirmary with a director of nurses and competent staff; a student health committee; and other interested but less directly responsible persons and departments. The public health nurse has to function between these departments, and her sphere has not yet been completely defined.

NURSING THE NURSERY SCHOOL

Certain functions are clearly hers. There is the nursery school, for example. Here she does morning inspection, supervises the menus, assists with the routine medical examinations, and advises with the staff and the parents. This is a demonstration school for the college students, so she has the additional duty of talking with students who are observing. Occasionally she teaches a class on subjects such as diet for young children or health safe-



Daily morning inspection is just another game to this little boy at nursery school

guards in the schools. The children themselves for the most part come from very privileged homes, and for that reason there is not a great deal of follow-up work for the correction of defects. Most of them are already under the care of pediatricians.

There are amusing little jobs in connection with the nursery school, such as a study of the use of various kinds of soap for children under five. And once the nurse was asked to discuss the physical benefits of going down a slide on one's back as against doing so on one's stomach!

PROTECTING HEALTH OF EMPLOYEES

The nurse is in charge of the health program for the employees. This originally consisted of a health consultation with each new employee, during which height, weight, and blood pressure were measured and blood taken for a hemoglobin test. Then the Widal test for typhoid fever was added for food handlers, and the following year one of the physicians made Wassermann tests. In the same year routine chest x-ray pictures of all the maids and cooks were made, through the coöperation of the local tuberculosis committee. Two active cases were discovered, and the demonstration has sold itself. New maids are now x-rayed each year, and retakes are

arranged in case of questionable findings, or for persons who have shown any symptoms of tuberculosis. This year medical examinations were started, for new maids only.

The program for employees has been a gradually expanding one, with some follow-up work, care of minor accidents and ailments, and advice on major health problems, which are referred to the local practicing physicians. Classes for the maids on health subjects are given from time to time with varying success.

During the past year more attention has been given to general environmental factors. Studies of lighting in the library and classroom buildings, with recommendations, were submitted to the administration. From time to time minor suggestions are made, such as a ventilator for a certain kitchen, or foot-flushing toilets, or covered hampers.

DORMITORY VISITING

In the nurse's work with the students, one of her main jobs is dormitory visiting. There are thirty-five separate houses, presided over by thirty-five house heads, who have varying degrees of experience with illness. At their request the nurse comes to the dormitory to advise in regard to the care of a student, in case of minor illness; or to decide whether the student is to go to

the physician's office or the infirmary for care, or possibly to have a physician visit her. The problem is not always primarily a medical one. Often it is clear to the head of the house that the student belongs in the infirmary, but she thinks the nurse may be able to help the student recognize her own need. Occasionally there is the student who is not so very ill but finds that illness may exclude her from a coming examination.

Various incidental problems come to the nurse's attention through a visit to a student in her room. The arrangement of the furniture may not be good for natural lighting during the daytime. The ventilation may be poor or the room overheated. Recently the nurse has given suggestions regarding the type of lamps the girls buy. She has tested illumination with a photometer, talked with the students about the quality of light they have, and given suggestions for bettering it. This advice may relate to the type of lamp, to placement, or to the buying of an inexpensive part that changes an old-style lamp to one with indirect lighting.

The nurse may find a fat girl munching the contents of a box from home, or a thin girl whose room is lined with empty soft drink bottles and boxes of dry biscuits. There are great advantages in seeing the student in her own surroundings—just as the visiting nurse finds it valuable to see a family situation.

PROMOTING HEALTHFUL ENVIRONMENT

This visiting, too, brings the nurse into close touch with the student houses. And attention to the students' environment is one of the primary functions of the public health nurse in the college. Occasionally a band of students discusses the dietary arrangements in their particular house. Or the problem may be one of noise, or of overheating. With the head of the house there is the ques-

tion of the maids and cooks as well as the students. A cook may have burned her hand that morning, or the first-aid box may need replenishing. While the nurse is there the head of the house may tell her about some other student besides the one she has been called in to see—one who is perhaps not sick but seems below par, or one who is having problems of adjustment to college, or who seems overfatigued with the schedule she is carrying.

It is in these informal talks that the public health nurse functions best. Indeed, her effectiveness depends upon her rapport with the heads of houses, as well as with the student health committee, the cooks, and the individual students. Her work is primarily a teaching job, and along with it go many odd jobs which occur in a large and complex set up. In many instances it involves solutions of problems without having to lay down one more rule or to institute formal procedure—both of which students hate.

Much of the nurse's time is given to health consultations with the students. These were instituted some years ago by a physician interested in promoting health, and at that time they were divided between the physical education staff and medical office. They comprise a screening method for detecting students below par, where the student body is too large for each to have a complete physical examination every year, and they also serve as a vehicle for much indirect health teaching. Appointments are made with individual students. Their health history during the intervening period and their habits and problems are gone into. The nurse may see ten such students a day, and may find that three out of the ten need to be referred to one of the doctors for some medical problem—generally a minor one. Occasionally she finds a student whom she refers to the vocational office, the psychiatrist, or the dean's office. Sometimes

the student returns to the nurse, if it is a problem within her sphere, such as checking up on a diet.

"HOW DOES ONE GET TUBERCULOSIS?"

The tuberculosis program for students is fairly complete. Freshmen are now required to have an x-ray picture before entrance. But there are always a number with doubtful or incomplete reports, and a number who need to be rechecked following symptoms that have developed at college, or as a follow-up after pneumonia. The college does not yet own an x-ray machine, and at present the students are taken to a state sanatorium some half hour away.

The hospital is a very fine example of community achievement and it also serves as a clinical center for the doctors of this locality, particularly in the early diagnosis of cancer and tuberculosis. The nurse accompanies the students in groups, both to give an abstract of their histories to the medical staff, and also because it affords an excellent time for informal health talks with the students. On the way to the hospital the students always ask *why* this is being done. (This *why* is one of the chief charms of students.) So the nurse goes over the figures on the incidence of tuberculosis in girls of this age group. "And what would happen if one of us had it?" they always ask. "And how does one get it?" and so on. It isn't as artificial a lecture as it sounds. They always ask.

In communicable disease control, the public health nurse has the job of discovering the contacts. She frequently goes into the dormitory where the case has occurred to talk with the house head, and to inform the students of their exposure and the measures they are to take. There has been only one small epidemic, consisting of forty cases of measles in the spring of 1938, when other schools and colleges in the East were also affected. Gastro-intestinal

cases, when more than one occurs in a house, are also investigated. Twice when there have been a number of these within forty-eight hours, the state health department has asked the college to do laboratory tests, but these were negative.

There are also studies and reports to be done, such as the study of lighting in the library, and reports on tuberculin tests and x-ray findings.

STUDY OF COLDS IN STUDENTS

In addition, a five-year study on the incidence of colds is being completed. One of the things it seems to show is that there are two separate patterns for cold-susceptibles, those who get frequent non-fever infections, and another group who have relatively few colds but do not get over them quickly. It is possible that preventive work might be done for these two groups on different bases. The calendar graph for all five years is very nearly identical, one year's line falling on top of the preceding one. There is a rise the first week of college, then a low period throughout October and November, a slight increase in early December, and a decided peak during the Christmas vacation. The students return in January just after the peak is reached. When one student asked what results the nurse was getting, and was told "Well, it seems to prove vacations are a bad thing," she shuddered and said "Don't you think you should stop that study?"

WORKING WITH THE COLLEGE STAFF

The public health nurse takes part in the medical staff meetings, together with the director of the infirmary and the clinic nurse. She consults with the head of the infirmary weekly, visits the hygiene classes from time to time to help in the correlation of the teaching with her more informal work, and attends the staff meetings of the nursery and primary schools whenever health is the major subject of discussion.

Some classroom teaching is done by the nurse. She has been called in to give a class on workmen's compensation and industrial disease to a group in economics, to discuss the physical development of young children in an education class, and to discuss nursing in a public health movements class, mental nursing to a psychology club, and the National Health Conference and the Wagner Health Act in another classroom.

It is evident, of course, that public health nursing in the college is still in its pioneer stage. Probably too many different activities have been taken on, at a sacrifice of quality. One solution lies in centering the emphasis in different years on different aspects of the work.

Perhaps the greatest value in having a public health nurse on the staff is that she represents a somewhat different ap-

proach and point of view. When there are 35 different environments in 35 different houses, it is sometimes a help to have someone in touch with each particular situation. The nurse's contribution may be arranging a special diet with a particular house head and a particular cook, or it may be arranging a protected environment for a person with a chronic ailment and unobtrusively observing how it is working out, or again it is noticing that a certain house has a disproportionate amount of some particular type of illness and looking into the problem which is presented.

It has been said that nurses go stale in college jobs, away from hospitals. I don't believe it. But the orientation is much more towards prevention and teaching than towards nursing techniques. I don't feel I'm going stale; I'm breathless trying to catch up!

THE AMERICAN JOURNAL OF NURSING FOR SEPTEMBER

The Nursing Council on National Defense

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Nursing Care of Osteomyelitis.....Ruth Evans, R.N.

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A Tentative Code

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Biennial Nursing Convention, Chicago, Illinois, May 1942

Criteria of a Good Examination

By ELIZABETH K. PORTER, R.N.

Since written examinations are increasingly used to measure professional competence for positions in public health nursing, these suggestions are most timely

THE PROBLEM of improving the professional nursing examination through the utilization of scientifically derived principles and techniques of measurement is one to which little consideration was given until very recent times. It now emerges as an important and urgent field for study with promise of rich returns both from an educational and from a social point of view. As one who has experienced all the struggles and anxieties involved in the taking and making of examinations, as well as in the familiar controversies which followed, the writer believes it is difficult to overestimate the importance of this growing, active interest of the nursing profession in devising more valid, accurate, and objective means of measurement.

The purpose of this article is to offer some very practical principles, suggestions, and precautions which are helpful for the individual who must construct examinations or collaborate with others in this task. Emphasis should be given to the deep obligation of every person charged with this responsibility, to make examinations represent the best that can be achieved with our present knowledge.

PURPOSE OF EXAMINATION

Stated in general terms, professional examinations are designed to ascertain the degree to which the individual possesses the knowledge, qualities, and abilities which seem to be associated with probable success in practice, in relation either to total professional attainments

or to attainments in some specified area. Such examinations serve a broad social function in their use as licensing examinations for the maintenance of professional nursing standards, and as qualifying examinations for the selection of those nurses best fitted to perform certain defined tasks. They serve an educational function in contributing directly and indirectly to the effectiveness of learning and teaching.

For the nurse herself, the professional examination is the gateway to the right to practice her profession, and increasingly to various public and governmental positions. For teachers, supervisors, and administrators, the results of examinations provide data for the continuous study and improvement of the content and methods of education, for the development of policies, and for guidance purposes. For society, they afford a reasonable guarantee of the nurse's professional competence.

The significance, then, of this widespread use of examinations in making crucial judgments on which the whole future career of an individual or the welfare of a group of people may hinge, is apparent. Both the nurse and society have tremendous interests at stake and have a right to demand intelligently applied measures.

It is true that we have become accustomed to the inevitability of examinations in the nursing profession, and have largely accepted the fact of their importance. It is unhappily true, however, that these examinations have not

always been entitled to the respect which they received. Past practice and even much present practice in examination technique has provided the type of evidence which has not always served as a fair basis for accurate appraisal of a nurse's attainments. Unwarranted deductions consequently followed with the result that superior ability was not always revealed, and society was not always safeguarded against incompetence.

"IT WASN'T A FAIR TEST!"

Among the most commonly heard criticisms are, first, the degree to which personal opinion had an opportunity to influence the verdict, and second, the narrowness of the ground covered in the test. Nursing examinations have been identified too frequently with the measurement of merely one component of professional ability, that is, the acquisition of information, whereas the ability to meet nursing situations adequately is a very complex one involving many discernible traits, skills, insights, knowledges, and specific abilities. The possession of factual knowledge became thereby the criterion by which a nurse was judged competent or incompetent.

These charges against examinations have been partially met by the recent scientific movement in the field of measurement. This constitutes a high technical study leading at once into difficult problems and intricate detail which the writer will leave for the moment to the specialist. But a wealth of material derived from this research has been published in nontechnical language, and we can turn this to account in making our own examinations or in cooperating with the specialists as the need may be.

The following suggestions, given in the form of directions, are offered as being indicative of the lines along which progress is being made. They are some of the important characteristics which distinguish a good examination and con-

stitute criteria for use in evaluation.

FIRST DETERMINE PURPOSE

Determine definitely the purpose the examination is to serve. Examinations serve many purposes. An examination may be intended to determine the progress which a nurse is making in some phase of nursing, or it may be intended, for instance, to assist in the selection of a candidate for a particular position. The principle and technique which underlie the construction in each case are similar, but the problems arising in relation to the specific content, and to the interpretation and use of results, may be very different. Let us suppose, for example, that an examinee fails to answer correctly a question concerning the significance of an immunization program. To the instructor, this may simply indicate a necessary modification in teaching plans, whereas the same failure on a qualifying examination for a public health position may mean the elimination of the examinee.

STATE OBJECTIVES CLEARLY

Begin with a clear conception of the objectives of the examination and state these with precision and clarity. This is a cardinal principle of measurement, and an essential prerequisite for the construction of any examination. The nature of *what* we wish to measure determines the type of examination to be used, the selection of test items, and the significance of the responses.

This brings us to an exceedingly important question: How are objectives determined and set up? The trend today is to define objectives in terms of required abilities, understandings, skills, attitudes, and so on. The following illustration presents one helpful approach to this problem:

State the general objective of the examination

First, we may begin by stating the general objective of the examination in

terms of a unified ability to meet a nursing situation. In determining this, we might ask ourselves: What should the nurse who passes this examination be able to do? What nursing situation, or situations, should she be able to meet?

Suppose the examination is one on the subject of tuberculosis. The answer to the above question then might be: She must be able to plan and to carry out in varying situations effective nursing care for patients with pulmonary tuberculosis, and to fulfill her responsibilities as a nurse in programs for prevention and control of the disease. Or, we may wish to measure a narrower ability, in which case the answer might be: She must be able to apply the principles of aseptic technique in procedures related to the immediate personal care of a patient with tuberculosis.

We are then ready to state the general objective of the examination—*what* we intend to measure. In this case we are going to measure: The ability of the nurse to plan and carry out in varying situations effective nursing care for patients with pulmonary tuberculosis, and to fulfill her responsibilities in relation to programs for the prevention and control of the disease.

Break down the general objective

Second, it is necessary to particularize this general objective. Although essential as a starting point, such an objective is too general to be of much value for measurement purposes. It represents a highly complex entity which must be subjected to a penetrating analysis to determine its component elements. The discernible qualities of the nurse who possesses such ability might be as follows:

1. A knowledge of those facts concerning the nature of pulmonary tuberculosis—the etiology, symptoms, course of the disease, complications, and treatment—which are basic for intelligent nursing care.

2. An understanding of tuberculosis as a communicable disease, and an ability to apply

the basic principles of aseptic technique to the special problems involved in preventing the spread of the disease.

3. An ability to assist the physician and others with special diagnostic and therapeutic procedures.

4. An ability to apply basic principles in making and carrying out effective plans for nursing care involved in both medical and surgical treatment of tuberculosis.

5. An ability to carry out skillfully the special nursing procedures involved in caring for patients with tuberculosis.

6. A knowledge of the psychological and social implications of tuberculosis for patient and family, and an ability to aid in the achievement of successful adjustment and rehabilitation of the patient and the adjustment of the family.

7. An understanding of tuberculosis as a family health problem, and an appreciation of how the nurse functions in preventing the transmission of the disease to the family and other immediate contacts and in securing the early diagnosis and treatment of the disease in contacts.

8. An appreciation of tuberculosis as an urgent public health problem, and an understanding of how the nurse functions in programs for prevention and control.

Analyze each objective in detail

The third and final step in setting up objectives of the examination consists in analyzing each of the above objectives still further in order to determine in detail, for example, what specific information the nurse should have concerning the nature of tuberculosis, what specific skills are involved in preventing the spread of the disease, or what specific knowledge and skill she needs in order to help in the successful adjustment of the patient.

Included in this detailed statement of objectives must be all those elements which should be guaranteed when we judge a nurse capable of assuming the responsibility of caring for patients with tuberculosis and giving health supervision to the family. Given some such list as this, we have a clear picture of what is to be measured, and a basis for the selection of the content and form of the examination.

SELECT FORM OF EXAMINATION

Select the type or form of examination which is most effective for evaluating the specific attainment under consideration. The truest evaluation of professional competence would be one based on evidence gained from observation of the nurse as she functioned in the actual life situation. Because of the obvious limitations of such a procedure, however, the examination system is substituted on the assumption that it is possible to secure by this means certain types of evidence which are dependable in identifying capacity and ability. It is clear, then, that we must select the type of examination which will provide the kind of evidence we are seeking.

It should be remembered, however, that there are qualities associated with professional success that do not lend themselves to measurement by means of paper-and-pencil tests; in this case the written examination must be supplemented by other measures. In other words, keep the written examination in proper perspective and use it only insofar as it is meaningful.

A discussion of the form of the examination usually centers around the two most commonly used: the essay form and the objective short-answer form. The essay question is the type used almost exclusively for professional nursing examinations until relatively recent times. We are all familiar with such questions as: What is being accomplished through local, state, and national agencies in securing early recognition of tuberculosis? The answer to this question would involve a rather lengthy discussion. In the objective short-answer examination, various forms have been designed as follows:

True-false—consists of a complete statement which the examinee is asked to study and then to indicate whether it is true or false.

Completion—consists of a statement with a significant word or words omitted; the

examinee is requested to supply the correct words.

Multiple choice—consists of four or five possible answers; the examinee is requested to choose the best answer, or the one or more answers which are correct.

Matching—consists of two parallel columns of related facts arranged in chance order; the examinee is requested to indicate those that belong together. These test items frequently deal with such related facts as: causes—effects, symptoms—treatment, symptoms—nursing procedures, disease—causative organism, and so on.

There are numerous variations of these forms but the above represent those most commonly used.

The relative merits of these two types have been discussed pro and con for years. There are certain values which can probably be tested better by the use of the essay, such as organization of data, individual interpretations, and individual capacity to discriminate in terms of relative values. On the other hand, the objective type is superior, generally speaking, in that it is more objective, more comprehensive, and more valid. In making a decision in regard to the form to be used, both the purpose of the examination and the specific ability to be measured are taken into consideration. As suggested previously, an examination which may be an excellent tool for an educational purpose may not serve at all for the purpose of selecting candidates for a position.

It is not possible to present here the various advantages and limitations of the different forms of examinations, nor the problem of designing the various types of questions. This entire subject, however, is discussed at length in numerous books published on tests and measurements.*

*The reader will find a detailed description of the various forms of objective test items, together with suggestions for their construction in *The Construction and Use of Achievement Examinations*, edited by H. E. Hawkes, E. E. Lindquist, and C. R. Mann, chapter 3, published by Houghton, Mifflin Company, Boston, 1936.

RELATION OF ITEMS TO OBJECTIVES

Be sure that each test item reflects a purpose which is directly related to the objective to be measured. In other words, test items must be directed precisely at what we wish to know about the examinee. If the purpose is to determine her ability to apply the principles of medical asepsis to a new situation, we cannot get the needed evidence by simply inviting her to recall the principles; we must set up a test exercise which requires her actually to make some application of the principles in question.

In days gone by, when the emphasis was largely on the testing of information, the task of formulating questions was not difficult. With the influence of modern educational ideas, however, this technique has become increasingly complex. Here are a few of the newer directions for examinations which reflect this influence:

Test knowledge in the way it is likely to be used in actual life.

Test ability of the student to analyze, to evaluate critically, to generalize from known facts.

Test insight into significant issues involved in a situation.

Test ability to use in actual practice all pertinent knowledge.

Test ability to make wise decisions on the basis of the evidence available.

Test ability to formulate plans for action.

Another important point, which needs no discussion, is that test items should be concerned with important, significant things. Nonessential material and trivialities serve no worth-while purpose in an examination.

USE CARE IN WORDING EXAMINATION

Exercise the utmost care in wording test items and in giving directions. It is necessary to be certain that if the examinee does not answer correctly it is because she cannot do so, and not because the question is ambiguous or the directions vague. The following specific instructions in regard to this aspect of

test construction represent some of the danger points:

1. State the question concisely.
2. Check the question to be sure that it means exactly what it says and nothing else; it should have but one possible interpretation. In a recent examination dealing with the nursing care of a patient with tuberculosis, this question appeared: What suggestions can you make in regard to the problem of teaching this patient the care of sputum? In answering the question, some of the examinees discussed the various methods which they would teach the patient to use in caring for his sputum. Others discussed the methods of teaching which might be effective in securing the cooperation of the patient toward this end. Still others included both of these aspects in their answer. Now, if the examiner had in mind any one of the above responses, the question should have been phrased so that no other response was possible.

3. Phrase the question so that it cannot be answered correctly if the examinee does not have the required knowledge, or that it cannot be answered by intelligence alone without any special preparation in the field.

4. Be sure the wording of the question gives no clue to the answer.

5. Give explicit directions; make these brief or detailed as the need may be. This applies more specifically to the objective form of examination, and depends somewhat on the experience and familiarity of the examinees with the form being used. If a group have had little experience with objective examinations, it is wise to make the directions quite detailed and to include perhaps a sample item. The following directions have been selected from the literature in this field and are illustrative of the type of directions which appear frequently:

Examine each statement below and decide whether it is true or false. If the statement is true, place a plus sign (+) in the blank

space opposite the statement. If the statement is false, place a zero (0).

You will have 90 minutes for this examination. Do not spend too much time on any one item; return to the more difficult items if necessary.

You will have 90 minutes for this examination; you are not expected to answer all the questions in this time limit.

Do not guess.

In the case of an essay examination some such directions as the following are sometimes found:

Before answering this question, make a written outline covering the points you are going to include.

Your mark will be based on your ability to interpret the facts relating to the social and economic status of this patient in terms of their significance for nursing care.

This question may be answered in outline form.

This examination consists of three parts. You will have two hours, and it is suggested that you give about equal time to each part.

6. If an essay question is used, indicate how detailed the answer should be. For example, the question: How is tuberculosis caused? could be answered correctly by stating very briefly: By the invasion of the tissues by the tubercle bacillus. There is nothing in the question to indicate whether this reply would be acceptable, or whether it would be better for the examinee to tell all she knows about the cause of tuberculosis. If a more detailed response is desired, this should be indicated by some such statement as the following: In discussing this question include (1) the exciting cause (2) theories of invasion (3) predisposing causes (4) how symptoms and clinical manifestations are produced.

7. Use only a vocabulary with which the examinee may be expected to be familiar.

Include a sufficiently wide range of test items to cover the entire field adequately. Who among us has not been

dismayed to find that an examination intended to estimate our total achievement in some field consisted of only ten short questions, several of which we could not answer! We were justified in believing that another examination on the same subject, but with a different selection of test items, might have given an opposite picture of our attainments.

COVER THE FIELD ADEQUATELY

It is, of course, clearly impossible to include everything, and examinations are, therefore, constructed on the theory of sampling. A representative sampling selected from the total content listed under each quality to be measured is of prime importance in securing an accurate estimate. A nurse may excel in her understanding of the treatment of tuberculosis and yet be totally incompetent in the essentials of home care. Therefore, if she needs both, she should be tested on both. There is much experimental evidence behind the statement: The larger the sampling, the more reliable the test.

To secure adequate sampling, the test items should be checked against the content of the examination as set up in the objectives to make sure (1) that all essential factors have been taken into consideration (2) that a selection has been made on the basis of those that have greatest significance and importance for the purpose.

It is not possible to give any definite answer to the question frequently asked concerning the number of questions which can be answered in any given length of time. The type of the response required and the form of the test item are both determining factors. A greater number of questions can be covered when the purpose of the examination is to test *knowledge* of principles than when the purpose is to test *ability to use* the principles in varying situations. When the objective form is used, ordinarily three to four true-false items can

be answered in one minute, and about 20 multiple choice or matching items can be answered in the time required for 50 true-false items. Such figures are, of course, only approximate.

SCORING OF ANSWERS

Be certain that the responses called for on the examination shall be of a kind that can be scored objectively. This is another cardinal principle of measurement. Marks are necessarily bound up with examinations, and much depends on them. In the professional nursing examination they are generally considered as representing the degree to which the nurse meets requirements; if the grade which she receives is not in keeping with her ability the purpose of the test is defeated.

One of the values insured by the controlled response of the objective type test is that there is only one correct answer; the results are always the same no matter who does the marking. On the other hand, one of the major criticisms against the essay type is that the mark which the examinee receives depends to a great extent on the judgment of the marker. Investigations have revealed wide variations in the marking of essay examinations even when the markers themselves were highly competent and had a stand-

ard for reference. Too many irrelevant factors are apt to influence the decision. Different examiners place different emphases on various elements in the examination. One examiner may value accuracy; another general understanding; or one examiner may read between the lines. If we must assign a mark, it is imperative that the mark coincide with actual achievement on the examination. Many techniques have been designed for securing controlled responses which can be scored objectively for both the essay and the objective form, and many newer systems of marking have come into use. Detailed discussions are available in the literature on the subject.

Although many phases of the problem have been left untouched, some essential steps in the improvement of the written professional nursing examination are given here. If we can isolate and define specifically and accurately those measurable qualities associated with success in nursing, if we can devise test items that will give accurate evidence of the degree to which these qualities have been attained, and if we can assign a grade or score which has meaning in relation to achievement, a good examination will be guaranteed. In other words, the examination will be valid, reliable, comprehensive, and objective.

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News from the S.O.P.H.N.'s

NINE PEOPLE met in Seattle in 1914 and formed the Washington State Organization for Public Health Nursing with a charter membership of fifteen, which included almost every public health nurse in the state. The 1940 records show a membership of 89 nurses and 4 lay people; there are 256 public health nurses now employed in the state. We realize that this leaves much work for our membership committee.

The S.O.P.H.N.'s plan of organization follows that of the N.O.P.H.N. very closely. While it does not function as a section of the Washington State Graduate Nurses' Association, it works in close coöperation with them and all our nurse members are members of the State Association. The president of S.G.N.A. becomes a member of the board of S.O.P.H.N., and the president of S.O.P.H.N. becomes a member of the board of Association.

The State of Washington, which is the most northwestern of the Union, has an area of 67,129 square miles. It is 238 miles from north to south and 370 miles from east to west. The Cascade mountains extending from the Canadian border on the north to the Columbia River on the south divide the state into east and west sides. Four highways cross these mountains. The most used highway crosses on the lowest pass, which has an elevation of 3004 feet. This pass is kept open the year around while our transcontinental railroads use tunnels.

Due to the distance between the eastern and western sides of the state, we try to alternate the place of the two annual board meetings to meet the convenience of the members.

The state is divided into five regional districts. Each has a chairman who selects her own committee to plan con-

ferences, institutes, or any meeting of interest to the public health personnel in that district. This year the state had two visitors from national organizations—Eleanor W. Mumford, associate for nursing activities, National Society for the Prevention of Blindness, and Dorothy Deming, general director, National Organization for Public Health Nursing. Regional meetings were therefore discontinued until fall.

In 1924 a student loan fund was started for public health nursing students. In 1935 this was made available to students in all nursing fields. A public health nurse is chairman of the loan fund committee.

Our representative at the meeting of the N.O.P.H.N. Council of Branches in January 28 in New York City was Anna R. Moore, state advisory public health nurse for the State Department of Health. In March a special board meeting was held to hear her report.

At this time, two committees were appointed. Three members of the S.O.P.H.N. were designated to serve on a joint committee with members of the State League of Nursing Education and a member of the Committee Nurse Examiners, Department of Licenses, to study the integration of public health into the curriculum of the schools of nursing. This joint committee met in April and prepared a recommendation to the curriculum committee of the S.L.N.E. for consideration.

The second committee, on orthopedic nursing, consists of five members—one representative from each quarter of the state, and the nurse consultant in the Crippled Children Service of the State Department of Health. It will work in coöperation with the N.O.P.H.N. Council on Orthopedic Nursing.

MAUD C. LaFERTE, R.N.
President, Washington S.O.P.H.N.

Your N.O.P.H.N.

THE ADVISORY COMMITTEE on Vocational Counseling is the youngest member of the N.O.P.H.N. family. It grew out of a recommendation of the Functions Committee* that the responsibility of the National Organization for Public Health Nursing lies in counseling rather than in actual placement of public health nurses. The Committee further stated that public health nursing placement should be more closely allied with the professional bureaus already serving other nursing fields and therefore the N.O.P.H.N. should place its emphasis on standard setting for public health nursing placement and on counseling through office and field service.

It was fortunate that at this time Anna L. Tittman, long associated with N.O.P.H.N. placement work through the Joint Vocational Service, was appointed to direct the Nurse Placement Service in Chicago. She has developed there, in line with the suggestion of the Functions Committee, a public health nursing placement service within an already established professional placement bureau, with a full-time public health nurse in charge. The Nursing Bureau of Manhattan and Bronx in New York City soon developed a similar service. Both are now approved for placement service in public health nursing by the N.O.P.H.N.

Concurrently with these developments, the N.O.P.H.N. Advisory Committee on Vocational Counseling crystallized its functions as follows:

1. To consider the N.O.P.H.N. program in counseling.
- *2. To study the placement services from a national vantage point.
3. To set standards insuring uniformity

* Gardner, Mary S. "Report of the Functions Committee." PUBLIC HEALTH NURSING, April 1938, p. 247.

and quality of public health nursing placement work.**

4. To promote, when necessary, additional placement bureaus. (In fact, standards were developed with the idea of regional placement bureaus. So far, neither of the two bureaus already established is regional in character and this phase in the development of placement work is under study at the moment.)

The Committee proposed and the Board of Directors voted that an additional assistant director be appointed to the N.O.P.H.N. staff, whose primary responsibility would be in the field of vocational guidance—which would supplement the guidance program carried on by the approved placement bureaus. Vocational guidance is found by the placement bureaus to be an extremely expensive service and only as much service as time and money will permit can be given by these agencies.

The Advisory Committee on Vocational Counseling is merely an infant and its secretary is newer than the Committee, so our course is still fairly uncharted. However, from the number of requests that have been received by mail and telephone and from the number of office interviews during the first year, it would seem that the program is developing rapidly and is far reaching in the area served. An analysis of one month's correspondence revealed inquiries of a vocational nature from 28 states and also Canada and Puerto Rico. Many inquiries have come from the student nurse group, and a number from high-school students who are beginning to show an interest in what constitutes the preparation of the public health nurse.

The development of merit systems, the expansion of professional divisions of state employment services, and the

** "Regional Placement Service." PUBLIC HEALTH NURSING, July 1939, p. 390.

newly organized placement service for social workers are all matters claiming the interest of the secretary. On the second of these topics, the N.O.P.H.N. Committee is working closely with the American Nurses' Association Committee to Study the Relationship of State and Local Employment Services to the Nursing Situation.

The Advisory Committee on Vocational Counseling is very closely tied up with the N.O.P.H.N. Education Committee, which sets the standards to be used by the vocational group and which has been described by Virginia A. Jones, secretary of the Education Committee, in the March 1940 issue of *PUBLIC HEALTH NURSING*. The vocational leaflets used are listed on our publications list as "Packet: What Everyone Should Know About Public Health Nursing," which is free upon request and which we would urge all persons giving vocational guidance in their local communities to have for reference.

ELIGIBILITY COMMITTEE

Contrasting in age is the Eligibility Committee, one of N.O.P.H.N.'s oldest committees, which at the last biennial business meeting was voted a standing committee. A small but representative group serves on this Committee, giving a great deal of their time and most careful individual consideration to the eligibility of applicants who do not meet the requirements stated in the bylaws for N.O.P.H.N. membership:

Graduation from an accredited school for nurses connected with a general hospital having a daily average of 50 patients or more. Curriculum should include practical experience in caring for men, women, and children, together with the theoretical and practical instruction in medical, surgical, obstetrical, and pediatric nursing.

Compliance with the state laws for registration of nurses in states where such laws exist.

Qualifications are evaluated in terms of what the applicant's school of nursing

had to offer, and whether there was affiliation or later postgraduate work which supplemented the basic services in the nursing school.

To the older graduate whose school does not measure up to requirements the Committee has always given special consideration, especially if the nurse had had years of public health nursing experience under qualified supervision. It would not seem justifiable to request such a nurse to take postgraduate work in basic clinical subjects after years of valuable service in the public health nursing field.

Ever mindful of increasing standards and working in close harmony with the N.O.P.H.N. Education Committee, the Eligibility Committee this year increased the length of affiliation or postgraduate work required of the recent graduate whose nursing school has less than a daily average of 50 patients. Although fewer and fewer applicants come from such small schools, there are still sufficient numbers to have the Committee take this step in order that these graduates may be better prepared to meet the needs of the field today.

It is most gratifying to note the number of nurses who act upon the Committee's recommendations. At almost every meeting some applications are re-evaluated on the basis of the fulfillment of previous recommendations made by the Committee, and the status of membership is changed from associate-nurse to full-nurse member.

May we urge that all our readers use every opportunity, in making contacts with prospective nurses, to stress the wise selection of a nursing school. An excellent source of information is "Nursing and How to Prepare for It," a copy of which can be secured from the Nursing Information Bureau, 50 West 50 Street, New York, New York.

At the Biennial Convention in Philadelphia in May 1940, the N.O.P.H.N. membership voted a change in the by-

laws that gives power to the Eligibility Committee to set agency membership qualifications which have been accepted by the Board of Directors. Since individual membership requirements have helped raise the standard of preparation of public health nurses, it is believed that

requirements for agency membership will help in bringing about improvements in public health nursing agencies. Plans are under way for the reviewing of such applications in the early fall.

ELLA L. PENSINGER, R.N.

Assistant Director

Elizabeth Smellie



Photograph by William Natman, Montreal

ELIZABETH SMELLIE, chief superintendent of the Victorian Order of Nurses for Canada since 1924, has been appointed by the Department of National Defense as matron-in-chief in Canada of the Royal Canadian Army Medical Corps to organize an overseas nursing service and will be attached to the office of the director general of Medical Services in Ottawa. She has been given a leave of absence from the Order, but will still continue to act in a consultant capacity.

This will not be the first time Miss Smellie has served her country. At the outbreak of the Great War in 1914 she

volunteered her services and went overseas shortly after the first contingent. For her services and devotion to duty she was mentioned in dispatches which culminated in the honor of her first decoration, the Royal Red Cross, First Class, at an investiture in Buckingham Palace in 1917. In her usual unassuming manner, when asked why she had been given this signal honor, Miss Smellie replied, "Oh, they were giving them out."

Miss Smellie received her nursing preparation at Johns Hopkins Hospital School of Nursing in Baltimore with postgraduate study in public health nursing after the Great War at Simmons College in Boston. Besides being a member of many Canadian organizations, she is a member of the National Organization for Public Health Nursing, and a member of the Advisory Nursing Committee of the Metropolitan Life Insurance Company. She is one of the few Canadians to have been appointed a fellow of the American Public Health Association and was elected first vice-president at its last annual meeting in October 1939.

Besides being decorated by the King in 1934, she was awarded the Mary Agnes Snively Memorial Medal in July 1938. This medal is given by the Canadian Nurses' Association for outstanding leadership in the nursing world.

NOTES *from the* NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

HONOR ROLL

Now that vacation is over and you're getting down to work again—one of the very first things to do is to make sure your agency is on the 1940 Honor Roll! All you have to do is have your staff 100 percent enrolled and then *let us know*.

No doubt there are many agencies which are already eligible (one-nurse services too) but just haven't notified us. If this is the case with you, won't you drop us a line today so that the name of your agency can be on our next list and an Honor Roll Certificate sent to you?

ALABAMA

Limestone Health Department, Athens
Pickens County Health Department, Carrollton
Cherokee County Health Department, Center
Kate Duncan Smith D.A.R. School, Grant
Metropolitan Life Insurance Nursing Service, Mobile

ARIZONA

Coconino County Health Service, Flagstaff

ARKANSAS

Van Buren County Department of Health, Clinton

CALIFORNIA

San Mateo County Chapter, American Red Cross, Burlingame
Nursing Division of the Sacramento City Health Department, Sacramento
Metropolitan Life Insurance Nursing Service, Santa Ana

COLORADO

*Johnstown Public School, Johnstown
Arapahoe County Public Health Association, Littleton
Pueblo County Public Health Nursing Service, Pueblo

CONNECTICUT

*Branford Visiting Nurse Association, Branford
Metropolitan Life Insurance Nursing Service, Danielson

*Agencies having been on the Honor Roll five years or more.

Town Nursing Service, Greenwich
*Visiting Nurse Association, Hartford
Stratford Red Cross Nursing Service, Stratford
*Visiting Nurse Association, Waterbury

FLORIDA

Franklin-Gulf County Health Department, Apalachicola
Dixie County Public Health Nursing Service, Cross City
Highlands County Health Department, Sebring
Palm Beach County School Nursing Service, West Palm Beach

IDAHO

South Central District Health Unit, Twin Falls

ILLINOIS

Henry County Sanitarium Board, Cambridge
Eastern Illinois State Teachers College, Charleston
Child Welfare Association, Danville
Decatur Health Department, Decatur
Hygienic Institute, LaSalle
Winnebago County Tuberculosis Association, Rockford
Department of Public Welfare, Division for Handicapped Children, Springfield
*DeKalb County Public Health Nursing Service, Sycamore

INDIANA

*Public Health Nursing Association, Indianapolis
*Visiting Nurse Association, Muncie
District Health Department No. 4, Rising Sun

IOWA

Appanoose County Nursing Service, Centerville
Clinton Chapter, American Red Cross, Clinton
Wayne County Nursing Service, Corydon
Decorah School Nursing Service, Decorah
Clark County Nursing Service, Osceola
Tama County Nursing Service, Toledo
Washington County Health Unit, Washington

KANSAS

Arkansas City Nursing Association, Arkansas City
Metropolitan Life Insurance Nursing Service, Lawrence

MAINE

Hancock County Health Service, Ellsworth

Metropolitan Life Insurance Nursing Service, Waterville
South Portland Branch, American Red Cross, South Portland

MASSACHUSETTS

Sturbridge Community Nursing Service, Sturbridge

MINNESOTA

Beltrami County Nursing Service, Bemidji
Bemidji School, Bemidji
District Health Office, Bemidji
Itasca County Nursing Service, Grand Rapids
International Falls Nursing Service, International Falls
Koochiching County Nursing Service, International Falls

MISSOURI

Metropolitan Life Insurance Nursing Service, Hannibal
Jackson County Health Department, Independence

NEVADA

*Nevada State Department of Health, Reno

NEW HAMPSHIRE

Belmont School Nursing Service, Belmont
Canterbury School Nursing Service, Canterbury
Chichester School Nursing Service, Chichester
*State Board of Health, Division of Public Health Nursing, Concord
Red Cross District Nursing Association, Franklin
Loudon School Nursing Service, Loudon
Newbury School Nursing Service, Newbury
Salisbury School Nursing Service, Salisbury
Warner School Nursing Service, Warner
Webster School Nursing Service, Webster
District Nursing Association, Winchester
School Nursing Service, Winchester
Wolfeboro Chapter, American Red Cross, Wolfeboro

NEW JERSEY

*Camden County Tuberculosis Association, Camden
Morris County Tuberculosis Association, Morristown
New Jersey Department of Health, Pitman District Office, Pitman
Visiting Nurse Association, Woodbury

NEW MEXICO

*DeBaca County Health Department, Fort Sumner
*Lea County Health Department, Lovington
*Quay County Health Department, Tucumcari

NEW YORK

New York State Education Department, Albany
Fordham Branch, Henry Street Visiting Nurse Service, Bronx
Orange County Committee on Public Health, Goshen
Hornell Public Schools, Hornell
*District Nursing Association, Lawrence
*Visiting Nurse Committee, Millbrook

NORTH CAROLINA

Sampson County Health Department, Clinton
North Carolina State Commission for the Blind, Raleigh

NORTH DAKOTA

Golden Valley County Health Department, Beach
Sargent County Public Health Nursing Service, Forman
Traill County Health Department, Hillsboro

OKLAHOMA

Metropolitan Life Insurance Nursing Service, Enid
District No. 1, Coöperative Health Unit, Tahlequah
Tulsa County Health Department, Tulsa

OREGON

Lake County Health Service, Lakeview
Division of Public Health Nursing, Oregon State Board of Health, Portland
Multnomah County Health Department, Portland
Lincoln County Public Health Association, Toledo

PENNSYLVANIA

*Visiting Nurse Association of Fleetwood and Vicinity, Fleetwood
Hazelton Chapter, American Red Cross, Hazelton
Visiting Nurse Association of Eastern Delaware County, Lansdowne
*Negro Bureau of Nursing, Philadelphia Health Council and Tuberculosis Committee, Philadelphia
Metropolitan Life Insurance Nursing Service, Richeyville
Fayette County Tuberculosis Society, Uniontown

RHODE ISLAND

*Barrington District Nursing Association, Barrington

SOUTH DAKOTA

Meade County Public Health Service, Sturgis

TEXAS

*Dallas Public Schools, Department of School Health Work, Dallas
Kerr County Public Health Nursing Service, Kerrville
Rusk County Nursing Service, Henderson

Southern Pacific Lines, Houston
Winkler County Health Unit, Kermit
Gregg County Health Department,
Longview
State Department of Health, District No.
2, Mineral Wells

WEST VIRGINIA

Clay County Health Department, Clay
Wyoming County Health Department,
Mullings

WISCONSIN

Iowa County State Department of
Health, Dodgeville
Burnett County Health Department,
Grantsburg
Oconto County Health Service, Oconto
Sheboygan County Nursing Service,
Sheboygan

WYOMING

Freemont County Public Health Nursing
Service, Riverton
Hot Springs County Health Department,
Thermopolis

STORIES BEHIND THE NEWS

The stories behind the news of the N.O.P.H.N. staff are seldom revealed outside the four walls of 50 West 50 Street. However, some can now be told:

Hats, gloves, watches, and tooth brushes may seem minor accessories to a winter field trip filled with important conferences and profound meetings. But after leaving a hat in Los Angeles, gloves somewhere in the State of Washington, and a watch on the Pullman; after losing tooth brushes in hotels from New York to California—we realize the importance of these mundane things of life. Perhaps we might be excused for losing even our head at times when in a period of three months, we visited 20 cities in 9 states, made 14 talks (some on a moment's notice), attended 9 other meetings, participated in 9 group conferences and 2 committee meetings, and still had time to sandwich in three weeks in the office in New York. But how much we learned!

We had not realized that corsages meant so much in our field-trip lives until we found ourself the only person

without one at the speakers' table at a recent state nurses' meeting. Long after the meeting was over, an apologetic bell boy brought to our door a lovely corsage of pink rosebuds with our name attached. Pantingly he said, "A big, fat, bald-headed man in Room 727 wants to know who you are and why you sent him pink rosebuds." Alas! Our lovely corsage had gone to Room 727 instead of 1227.

Another staff member speaks:

And minor tragedies! What of the carefully prepared address on the value of promoting a preschool program in a community—a thirty-minute paper quoting from authoritative literature, and even analyzing in detail the type of service suitable to the size of the city addressed? Then, en route from train to auditorium, the hostess remarks: "I am so glad you are encouraging our program of *prenatal* service!" Just a few letters changed in the note of invitation by a hurried secretary: preschool—prenatal.

Or this for real tragedy! An unseasonably hot day, a fresh lovely hair wave carefully netted for a bath before dressing for the banquet. We approach the tub, drop the waste stopper, turn the hot water faucet—and ruin! The shower sprays water over the new wave instead of the faucet filling the tub! Someone left the shower-control handle "up" instead of "down," but the wave was very definitely down!

One last picture: A small city, a strange new health officer, a first visit in many years from the N.O.P.H.N.

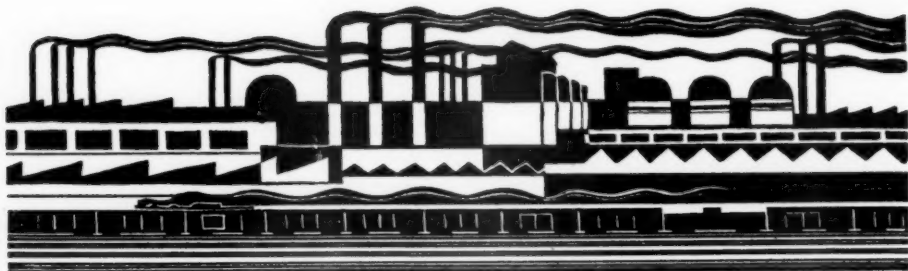
Health officer: "Good morning, it was nice of you to call, but my staff of nurses decided not to buy any insurance!"

N.O.P.H.N. staff member: "But—but—Doctor—we—I don't represent—"

Health officer: "No, thank you. I know you sell insurance. We are not interested."

N.O.P.H.N. staff member, firmly: "You *must* let me explain—"

And she did. Yes, he apologized.



WHAT HELP CAN INDUSTRIAL NURSES SECURE?

WHAT HELP can industrial nurses receive from a state health department? This question was discussed at the lively round table on industrial nursing at the Biennial Convention in Philadelphia on May 14, 1940, attended by a hundred nurses who are engaged in or interested in this field.

The group's opinion about the value to industrial nurses of a state consultant nurse was asked by Ruth Scott, nurse supervisor in Indiana, who has been assigned to act as consultant on industrial nursing besides her regular district supervisory duties. This help from the Indiana State Board of Health is most welcome to industrial nurses of the state, according to Victoria Stralko of the American Maize Products Company, Roby, Indiana, who said that the nurses are now coöperating in a survey of industrial nursing by the Board of Health.

The splendid industrial hygiene sym-

posium held in Chicago last fall by the Illinois State Department of Health at the request of the Chicago Industrial Nurses' Association was cited as an example of the service industrial nurses may receive. (See April issue, page 277.)

Nursing units of state health departments are increasingly assuming some responsibility for helping industrial nurses, according to Ruth Kahl, regional public health nursing consultant of the United States Public Health Service. She said that state consultant nurses frequently include industrial nurses in their conferences, make available to them health materials, and act as a liaison person between the industrial nurse and the industrial hygiene division of the state health department.

The discussion of other questions raised at this round table will be summarized in this section in subsequent issues.

WOMEN WORKERS IN DEFENSE INDUSTRIES

HEALTH safeguards for the protection of women workers in defense industries are discussed in a readable little pamphlet just issued by The Women's Bureau of the U. S. Department of Labor. The bulletin, called "Effective Industrial Use of Women in the Defense Program," covers factors which are important not only in defense industries but in any industry employing women—

such as hazards to which women are especially susceptible, and the relation of working hours, the worker's clothing, plant lighting, the provision of seats, and plant sanitation to the health and productivity of employees. The nurse will find this publication an invaluable reference. It is available from the Superintendent of Documents, Washington, D.C., for 10 cents.

"THE EYES HAVE IT"

HOW EYE accidents are prevented in industry, through the education of workmen and the use of goggles, masks, and other protective equipment, is dramatically portrayed in "The Eyes Have It," a new sound slide film sponsored by the National Society for the Prevention of Blindness.

In this educational film the tragedy of blindness resulting from carelessness is contrasted with the absence of eye injuries where hazards are recognized and a continuous safety campaign is conducted. Combining humor with a serious presentation of the factors responsible for eye accidents in industrial plants, this educational film is intended for groups of workmen and foremen as well as safety directors.

The importance of the problem, which is presented graphically and simply in this film, may be judged from these facts: There are in the United States today close to 8000 persons who have

been blinded by the eye hazards of industrial occupations and more than 80,000 persons who have lost the sight of one eye as a result of these hazards. To this total there are added each year at least 75 persons who lose the sight of both eyes and 2000 persons who lose the sight of one eye because of industrial or occupational hazards. The number of men and women in industry who lose permanently part of the vision of one or both eyes undoubtedly runs into tens of thousands each year.

The film was produced and directed by Harry Guilbert, a member of the Industrial Advisory Committee of the National Society for the Prevention of Blindness. Mr. Guilbert is director of the Bureau of Safety and Compensation for the Pullman Company.

Inquiries concerning the film should be addressed to the National Society for the Prevention of Blindness, 50 West 50 Street, New York, N.Y.



Safe and happy because his eyes are protected



EDITED BY ANNA C. GRING

CARE OF POLIOMYELITIS

By Jessie L. Stevenson, R.N. 230 pp. The Macmillan Company, New York, 1940. \$2.50.

Many nurses are familiar with Miss Stevenson's practical articles on the nursing care of poliomyelitis that have appeared in nursing journals in recent years. This book in five chapters presents the subject of poliomyelitis as follows: The Problem; The Acute Stage; Convalescent Care, both from the point of view of nursing care and physical therapy; and Later Care or Functional Restoration. In the Appendix detailed directions are included for the making of splints, the making of a corset, and a device for moving the patient from the bed to an underwater tank.

Throughout the book the author emphasizes the importance of teaching both the patient and the family the underlying principles basic to treatment in order that they can assume some responsibility for carrying out the necessary technique involved in care. The suggestions for nursing care in the chapters on the acute stage and on convalescent care are clearly presented. These chapters reflect the results of the author's years of study and experience through which techniques in the home nursing care of poliomyelitis were perfected.

The chapters on Convalescent Care and the Appendix are well illustrated.

This volume might well be used as required reading for nurses participating in

crippled children's programs and those preparing for such participation.

RUTH A. HEINTZELMAN, R.N.
Washington, D. C.

SCHOOL HEALTH PROBLEMS

By Laurence B. Chenoweth, M.D. and Theodore K. Selkirk, M.D. 419 pp. F. S. Crofts and Company, New York, second edition, 1940. \$3.

The first edition of this text appeared in 1937. The general plan of presentation used in the earlier edition has not been materially altered. Several features have been added which bring this discussion of health problems in the school up to date, and make the book a most valuable one for the school administrator, teacher, school physician, and school nurse. It is particularly well adapted for use in college classes.

The additions in this volume include a new chapter on school sanitation, one on health education, and an appendix with excellent discussions on quarantine regulations and on reading disabilities. The glossary has been enlarged. This feature of the book should be of special value to the teacher and school administrator.

A brief history of the school health movement is given in the first chapter. The next five chapters are given over to an informative account of growth in children. A comprehensive discussion of the physical examination of pupils follows. The material on communicable

diseases, immunization, tuberculosis, and the school child is complete and up to date. The chapters devoted to the educational aspects of the physical examination, classes for the exceptional child, mental hygiene, and the accident problem and the school are very good. The "Outline of School Health Administration" by Dr. Richard A. Bolt, and the numerous references at the end of each chapter are certain to enhance the value of the book for anyone who has occasion to use it.

The material in this book has been carefully prepared. Its style is clear and direct. Fundamentals are stressed. Throughout the text the emphasis is on that most important aspect of modern health education, prevention. This book belongs in the library of teachers, colleges, school administrators, and public health organizations.

LLOUELLA LOUISE HAAGE, R.N.
Jersey City, New Jersey

CHILD PSYCHOLOGY FOR PROFESSIONAL WORKERS

By Florence M. Teagarden, Ph.D. 641 pp. Prentice-Hall, Inc., New York, 1940. \$3.25.

The scope of this book is broader even than the title would suggest. The first hundred pages, for example, are devoted to a general discussion of heredity in its theoretical and clinical aspects, and to general information about pregnancy and birth. A great deal of the text throughout the book consists of references to the research and opinions of other authors. This encyclopædic inclusiveness makes for sketchiness and cumbersomeness. Nevertheless, it is wholesome for the reader to be thus reminded that our present knowledge of the whole sphere of psychology is a very incomplete and heterogeneous mixture of observations and opinions, not to mention prejudices. The great number of references provide an extensive bibliography for a reader who wishes to explore further.

Early chapters deal with infancy, the

preschool age, and habit training, and present the generally accepted modern concepts of how the child develops emotionally and how he is to be handled.

The chapter on the sex life of the child is focused predominantly on theory and on abnormalities and rather slights the positive aspects of the subject. The chapter on behavior problems is devoted principally to the etiological factors and to prognosis in delinquency.

The best chapters and the most valuable are those devoted to the child's relationship to home, institutions, and school, and the one which discusses intelligence and testing. "The Child and His Home" goes into some of the fundamentals that make the difference between the "good" and the "bad" home from the emotional point of view. Two important chapters deal with foster homes, institutions, and adoptions.

The chapter on schools emphasizes the vital matters of teachers' attitudes and the child's emotional response to school, which to the psychiatrically-minded person loom so large in importance for the child's development. These chapters present material and a point of view which ought to be familiar to all those who work with children, particularly nurses, social workers, teachers, psychologists, and physicians.

BENJAMIN SPOCK, M.D.
New York, New York

REHEARSAL FOR SAFETY

By Fanny Venable Cannon. 132 pp. E. P. Dutton and Company, Inc., New York, 1939. \$1.

Six spirited plays concerned with specific safety situations are offered by Fanny Venable Cannon in this small volume. The dramatic quality of the episodes as well as the clearly convincing consequences involved in the action makes these presentations suitable for children in the elementary grades. Emphases include possible dangers at home, in the street, and at play. In a number of situations the accidents are inferred;

in others the dangers are actually presented.

From a sound psychological point of view it would have been more desirable to include also positive aspects of safe behavior, for safe living grows out of attitudes and behaviors rather than out of responses to particular catastrophic occurrences. Therefore this writer suggests the use of these playlets to accent or stress an aspect of a much wider safety education program.

EDITH GANN KNIBERG
Newark, New Jersey

PUBLIC HEALTH NURSING IN OBSTETRICS PART I

Maternity Center Association. 83 pp. The Association, New York, 1940. 50c.

There has long been a need for a textbook on maternity care for public health nurses, and Part I of this book which is to be published in three parts is certainly the beginning of the answer to this need. The explanation of various common terms is a decided help in the clarification of conflicting ideas. This book will be an aid to the nurse in better understanding the condition of her patient, in interpreting reports, and in writing records. Maternal and infant mortality statistics will mean more to many nurses when they know on what basis these figures are computed.

The questionnaires should stimulate the nurse to take inventory of the facilities for care in the community, and how these resources may be used to the best advantage.

It is a real pleasure to see that other factors are considered besides the actual medical and physical needs of the mother, such as recreational advantages, housing, transportation, religion, and community customs and resources. The importance of considering the entire family when making plans for maternity care cannot be overemphasized.

ALICE M. ANDERSON, R.N.
Brooklyn, New York

THE CHANGING TASK OF THE SCHOOL PHYSICIAN

By Benjamin Spock, M.D., with introductory note by Caroline B. Zachry. 25 pp. Reprinted from *Progressive Education*, New York, 1940. 50c each; 30c each for three or more copies.

This pamphlet is a series of five articles published during the past winter in the *Progressive Education* magazine.

In discussing conditions which cannot be revealed by the usual school medical examination, Dr. Spock says that "if the school is to know each pupil from a broad health point of view it must get some history and the more the better. Most schools get little history, for very practical reasons. But if the need is widely understood efforts can be made to gradually remedy the lack."

Attention is given to the physician's supervision of sanitary and hygienic conditions of the school building. The need for understanding of emotional problems in school children and the value of a specially trained worker in emotional problems of children to assist the school medical staff is also discussed.

This pamphlet is a welcome analysis of a professional job too long assumed to be fulfilled when the school physical examination has been completed. Whenever the functions of the school physicians, as outlined by Dr. Spock, are applied, the task of the school physician will emerge as a career in preventive pediatrics and public health.

GEORGE M. WHEATLEY, M.D.
Astoria, New York

PERSONNEL ADMINISTRATION IN THREE NON-TEACHING SERVICES OF THE PUBLIC SCHOOLS

By Hazel Davis, Ph.D. 323 pp. Bureau of Publications, Teachers College, Columbia University, New York, 1939. \$2.50

The author of this most interesting study has made a real contribution to the administration of the three services of attendance, school nursing, and secretarial service. The study was much needed, and while it is not complete from any single angle, it shows a decided need for more study and more action to

improve these services in the schools.

Dr. Davis studied twelve schools within a radius of three hundred miles of the city of New York and probably in several different states. Observation and study were limited to certain principles and practices in personnel administration in each of the three services and did not cover all aspects of any of the services. The author's goal was to make an evaluation of the contributions each service makes to the educational process. In the delimitation of the subject Dr. Davis rejected all phases of procedures on which she could not personally obtain dependable information.

The selection of items to be studied is excellent. To the specialist in the fields the work might have been enhanced if she had added some information on the special training of the personnel judged.

This reviewer read the book with the school nurse as her special interest. It was rather shocking to realize that school administrators were so lacking in interest and understanding of the contribution which school health services should make to the educational processes of the school. The main items which seem to show this lack were those relating to performance of work, planning and leadership, and the method of inducting new employees into the system. Hopeful signs were shown in the salary schedule on which nurses were paid, the terms of employment, and the distribution of personnel. Selection and assignment, conditions under which the nurses were required to work in various schools, and the planning of their school day were decided disappointments.

Certainly when so much money is spent by public schools for the three services studied here, it is not too much to expect that school administrators should be aware of the failures to receive services of sufficient caliber to justify the expenditure. Since Dr. Davis did not attempt to show what should be done about these matters in order to

improve the efficiency of the school system, it is time that somebody took the leadership to determine places through which authentic information to school administrators can be disseminated.

Dr. Davis says: "The superiorities which served as a basis for high ratings in administration in many cases represented only a partial carrying out of the personnel procedures in question, as compared with total absence of the procedures in other places." The reviewer suggests to administrators of school nursing programs that they should get this book, attempt to evaluate their own schools by some similar procedure, and then select some manner by which the presentation of their programs may be made worth while to their school systems. Apparently the amount of money spent in relation to the amount of adequate service received shows little or no relationship. Should not something be done about this?

GERTRUDE E. CROMWELL, R.N.
Des Moines, Iowa

THE FORTIFICATION OF FOODS WITH VITAMINS AND MINERALS

Series of articles reprinted from July 1939 Milbank Memorial Fund Quarterly, 262 pp. Obtainable from Milbank Memorial Fund, 40 Wall Street, New York. 25c.

The topic is discussed in these five papers by outstanding nutrition research workers in terms of basic nutrition principles, a general program for better nutrition, public health aspects and governmental control problems involved, and the retention, restoration, and fortification of vitamins in foodstuffs.

The authors present evidence that American diets, especially among low-income groups, are deficient, and that health would be improved by insuring more adequate calcium, iron, and vitamins A, D, and B complex. Methods advised are adding B complex to cereal foods and vitamins A and D to dairy products.

MRS. ANNA DEPLANTER BOWES
Harrisburg, Pennsylvania

RECENT PUBLICATIONS AND CURRENT PERIODICALS

SCHOOL

PUBLIC HEALTH EDUCATION—HAS IT SUCCEEDED? Walter Clarke, M.D. *Journal of Social Hygiene*, April 1940, p. 145.

Six criteria of successful health education dealing with syphilis and gonorrhea are discussed, followed by a leader's opinion of progress, prognosis, and future objectives.

THE OPHTHALMOLOGIST AND THE SIGHT-SAVING CLASS TEACHER IN CONSERVATION OF VISION. Edmond L. Cooper, M.D. *Sight-Saving Review*, March 1940, p. 19.

Emphasizes the relationship of the ophthalmologist and the sight-saving class teacher in handling the problem of the partially-sighted child.

OPTIMUM WORKING CONDITIONS FOR THE EYE. C. E. Ferree, Ph.D., and G. Rand, Ph.D. *Sight-Saving Review*, March 1940, p. 3.

THE RELATION OF HEALTH EDUCATION TO PUBLIC ADMINISTRATION. John W. Studebaker. Address delivered before American Association for Health, Physical Education and Recreation, Chicago, April 25, 1940. Federal Security Agency, United States Office of Education, Washington, D. C.

The answer to the question, "who should be responsible for the school health program?" is emphatically "the school authorities," according to Dr. Studebaker.

SAFETY EDUCATION: A SECTION OF PART III OF A GUIDE TO THE TEACHING OF HEALTH IN THE ELEMENTARY SCHOOL. Prepared by Florence C. O'Neill. University of the State of New York Bulletin, Albany, N. Y., 1937. Free to New York State personnel; 15c. outside the state.

Practical helps for teachers, parents, and nurses in presenting safety measures to children in the elementary school. A comprehensive bibliography for children and adults is included.

SHOULD THE SCHOOL HEALTH SERVICE BE ADMINISTERED BY DEPARTMENTS OF EDUCATION OR BY DEPARTMENTS OF HEALTH? Charles L. Outland, M.D., and H. Warren Buckler, M.D. *School Life*, April 1940.

Both writers agree that closer cooperation is desirable, irrespective of whether the school health service is administered by the department of education or the department of health.

COÖPERATION OF BOARD OF EDUCATION AND DEPARTMENT OF HEALTH IN THE CARE OF THE HANDICAPPED CHILD. Joseph G. Molner. *Journal of Exceptional Children*. November 1939. p. 61.

There is little new in this but it is a good statement on coordination.

PSYCHIATRIC CLINICS FOR CHILDREN. Helen Leland Witmer, Ph.D. 437 pp. The Commonwealth Fund, New York, 1940. \$2.50.

TOMMY'S FIRST VISIT TO THE DENTIST. Anice Carlisle Swift. 10 pp. Bureau of Public Relations, American Dental Association, Chicago, 1938. 5c.

A delightful presentation of Tommy's first visit to the dentist.

THE PROTECTION OF CHILDREN FROM TUBERCULOUS ADULTS. Fairfax Hall, M.D. *Journal of the American Medical Association*, November 18, 1939, p. 1873.

Recommends periodic health examinations for all those in intimate contact with children.

ACCIDENT FACTS. 112 pp. Statistical Bureau of National Safety Council, Inc., 20 North Wacker Drive, Chicago, 1940. 50c. for single copies, lower prices for quantity orders.

Accident facts for 1939 now available.

CONFERENCE ON PROBLEMS IN SCHOOL SAFETY ADMINISTRATION. 35 pp. Abstract of Proceedings, January 19, 1940. Division of General Education, Center for Safety Education, New York University, New York.

STUDIES ON GROWTH AND DEVELOPMENT OF ADOLESCENTS AND THEIR IMPLICATIONS FOR THE HEALTH PROGRAM OF THE ADOLESCENT. William Walter Greulich, Ph.D. *Journal of School Health*, May 1940, p. 133.

A discussion of the growth pattern, some limitations of height-weight tables based on group averages, the relation of pituitary and gonadal hormones to growth and development, the probable value of the menarche as a criterion of sexual maturity, and the degree of variability in the developmental status of children of the same chronological age, during adolescence.

Brochures, research studies, reprints, bibliographies, visual aids, and radio scripts on safety education can be secured for minimum fees from the Center for Safety Education, New York University, 20 Washington Square, North, New York.

NEWS NOTES

• Problems of health and public welfare services involved in the national defense effort will be coordinated through the cooperation of four governmental agencies, according to an announcement by Harriet Elliott, member of the National Defense Advisory Commission, in charge of the Consumers Protection Division.

The Defense Commission has approved plans calling for establishment of a coordinating committee consisting of the following:

Thomas Parran, surgeon general, U. S. Public Health Service—to direct activities involving public health and medical problems.

Katharine F. Lenroot, chief of the Children's Bureau, U. S. Department of Labor—to direct activities relating to children.

Arthur J. Altmeyer, chairman, Social Security Board—to direct activities relating to social security and welfare.

Dr. Milburn L. Wilson, director, Extension Service, Department of Agriculture—to direct activities concerned with nutrition problems.

The work of this committee, acting with Commissioner Elliott, will emphasize the importance of maintaining and improving the standards of health and welfare to the end that American citizens may be physically prepared for whatever responsibility they may face in the defense program.

• A Nursing Council on National Defense has been formed with the following member organizations:

American Nurses' Association
National League of Nursing Education
National Organization for Public Health Nursing
Association of Collegiate Schools of Nursing
National Association of Colored Graduate Nurses

One of its chief functions will be to unify all nursing activities which are directly or indirectly related to national defense. As a first step it plans to make

a national inventory of our nursing forces in order to know what is available in case of need. For further details see *The American Journal of Nursing* for September.

• "Striking changes have taken place in the general public health status of Tennessee and Mississippi since the present programs were launched some ten years ago," according to the February number of *The News-Letter* of the Commonwealth Fund. In Mississippi there has been an increase of 15.3 percent in the number of people served by full-time county departments outside of cities of more than 100,000; in Tennessee, an increase of 16.7 percent. More people are employed in all public health categories and there is a great increase in the number of nurses—from 33 to 117 in Mississippi, and from 69 to 128 in Tennessee.

• Maude Hall has been appointed acting superintendent of the Victorian Order of Nurses for Canada during Elizabeth Smellie's appointment as matron-in-chief in Canada of the Royal Canadian Army Medical Corps. Beatrice Creasy will act as assistant to Miss Hall.

• Six regional health education conferences on school nursing were conducted by the Division of Health, Safety, and Physical Education of the New Jersey Department of Public Instruction during the past winter and spring months. Among the current problems of health supervision presented at the various meetings were: dental health education, health factors in vocational education, health in relation to the under-privileged child, early detection of orthopedic cases, and significance of rheumatic fever. As a result of these meetings, members of

the group were keenly interested in further study and in the extension of community health facilities.

- An announcement has been made by Community Chests and Councils, Inc., that Charles Francis Adams has accepted the chairmanship of the Community Mobilization for Human Needs for 1940. Mr. Adams is president of the Community Federation of Boston, Mass., and was at one time Secretary of the Navy.

- The appointment service of the Henry Street Visiting Nurse Service in New York City is to be expanded so that nursing service will be available on an hourly basis at any time from 8:30 a.m. to 9:00 p.m. The service will meet the needs of patients who wish care at a specific time, but who do not require a full-time nurse. The visiting nurse will stay for any length of time up to four hours at each visit, at a charge of \$2 for the first hour and 75 cents for each additional half hour between 8:30 a.m. and 5:00 p.m., with a slightly higher rate between 5:00 and 9:00 p.m.

The organization's publicity on this enlarged appointment service describes its program as follows: "The Henry Street Visiting Nurse Service is a community nursing service giving nursing care to anyone who is sick at home and under the care of a physician. Like a hospital it has private, semiprivate, and free services. The appointment visits correspond to the semiprivate or free service of the hospital." The non-appointment nursing visits, which are made according to the physical needs of the patient and the convenience of the nurse's schedule, are \$1.25 or less, according to the patient's ability to pay.

- The Chamber of Commerce of the United States in coöperation with the

American Public Health Association has announced the awards for the 1939 city and rural health conservation contests. Awards were made on the basis of the competent manner in which a community is meeting its health problems, according to certain criteria. The following are the winners of the city contest:

Group I, cities of over 500,000 population, Milwaukee, Wis.; Group II, cities of 250,000 to 500,000 population, Memphis, Tenn.; Group III, cities of 100,000 to 250,000, New Haven and Hartford, Conn., tie; Group IV, cities of 50,000 to 100,000, Newton, Mass.; Group V, cities of 20,000 to 50,000, Greenwich, Conn., and Plainfield, N. J., tie; Group VI, cities under 20,000, Englewood, N. J.

Winners of the rural contest, which are chosen geographically, are:

Northeastern Division, Alger-Schoolcraft Health Unit, Mich.; Eastern Division, Fayette County, Ky.; Southeastern Division, Lauderdale County, Miss.; South Central Division, St. Mary's Parish, La.; Western Division, Wasco County, Ore.

In the Canadian rural health contest the winner is St. James—St. Vital Health Unit, Manitoba.

- The South Carolina State Nurses Association will hold its annual meeting on October 17-18 at the Oregon Hotel, Greenwood. The theme of the convention will be "Educating the Nurse to Serve the Public."

NEW APPOINTMENTS

(For N.P.S. appointments see page 532)

Mrs. Gertrude R. Folendorf, Member of the Federal Advisory Committee on Services for Crippled Children to advise with the U. S. Children's Bureau, Washington, D.C.

Christina Mackenzie, Instructor in Public Health Nursing, University of California, Berkeley, Calif.

Elizabeth Lynch Sewell, District Supervising Nurse, State Department of Health, Syracuse, N.Y.

Attention: N.O.P.H.N. members! Watch for P.H.N.!

Our Contributors This Month

The Pacific Coast has contributed two articles to this magazine—one from a rural and one from an urban agency. **Miss M. Grace Watson**, who wrote the article on "Staff Conference in a Rural Health Unit," is supervisor of public health nurses of the Thurston-Mason-Olympia District in Olympia, Washington. Before entering the field of public health nursing she had extensive executive and teaching experience in hospitals on the West Coast. She received her Certificate in Public Health Nursing and B.S. degree at the University of Washington and has done school nursing in Tacoma.

Dr. Helen A. Cary is director of the Division of School Hygiene of the Portland (Oregon) Bureau of Health. She was previously adviser to women at Reed College in Portland. She is vice-president of the American School Health Association, and vice-president of the Oregon State Nutrition Council. She has contributed articles to the *Journal of School Health* and (in collaboration with Dr. William Levin) to the *American Journal of Public Health*.

The second article in the series on dental health is by **Dr. Emory W. Morris**, who is general director of the W. K. Kellogg Foundation. Dr. Morris was in private practice for five years before joining the staff of the Foundation in Battle Creek, Michigan in 1933. He is the author of several articles in dental journals, on community dental health programs.

Frederic G. Elton brings to his work a rich background of experience in the fields of both industry and vocational education. He has held positions as head of industrial department, Brockton (Mass.) High School; production superintendent in the Marsh Motor Company in Brockton; and supervisor of training and advisement of the Federal Board for Vocational Education. He is now senior

district supervisor of rehabilitation of the New York State Education Department; editor of the *Rehabilitation Review*; and a member of the staff of the Post-Graduate Medical School and Hospital, New York City.

Helen Elizabeth Hestad will be recalled by our readers as co-author of the useful staff education outline on Infant and Preschool Health in the December 1937 issue of this magazine. She is maternal and child health consultant of the Community Health Service of Minneapolis. She has done school nursing in Wisconsin and Minnesota and was a staff nurse with the Minneapolis Infant Welfare Society before it merged with the Visiting Nurse Association to form the present joint organization.

The N.O.P.H.N. Committee on Nursing Administration, which directed the study of tuberculosis nursing records, is composed of 12 members representing various types of agencies and various interests in public health nursing. Its members are all administrators, who are interested in this type of problem. **Dorothy E. Wiesner**, who did most of the work in making and writing the study, is statistician of the National Organization for Public Health Nursing.

The article on "Citizen Committees in Official Agencies" was written in response to a steadily increasing demand from the field for help with the organization and use of these lay groups. Probably no one in the country has a better understanding of the possibilities for use of the layman in planning, executing, and interpreting health programs than **Evelyn K. Davis**, whose suggestions are based on nationwide contacts with agencies that utilize lay participation. Miss Davis is assistant director of the National Organization for Public Health Nursing. As this goes to press she is vacationing on a canoe trip on the Minnesota lakes.



This issue of the magazine is dedicated to Lillian D. Wald, founder of the Henry Street Settlement and the Henry Street Visiting Nurse Service in New York City, and first president of the National Organization for Public Health Nursing. A tribute to Miss Wald, who died on September 1 in Westport, Connecticut, appears on page 639.

PUBLIC HEALTH NURSING

Official Organ of the National Organization for Public Health Nursing, Inc.

A House Founded on a Rock

FAMILIAR to all of us is the Biblical story about a house that was built on a rock and another that had its foundation in the sands. When the storms came and the winds blew, the first house was not shaken, but the second was dashed to pieces.

This parable has implications for our democracy. The building of a foundation which will preserve the inner strength of our democracy against external and internal danger is the deepest concern of every thinking citizen today. The bricks of this foundation are the ability of our country to meet the needs—the basic, human needs—of its people, to give them freedom of opportunity, to remove the causes of fear and insecurity and unhappiness which now face a large proportion of our population.

As communities from coast to coast approach the 1940 Community Mobilization for Human Needs, this vital necessity to preserve intact the rock upon which a strong democracy depends must not be forgotten. For one of the methods by which our country has traditionally met the social and health needs of its sick, its needy, its helpless, and its children is through the community agencies supported by voluntary contributions.

This responsibility is voiced in incisive words by Sidney Hollander, president of the Council of Jewish Federations and Welfare Funds:

We are beginning to worry about a possible assault on our shores from without. But the greater danger by far to our national existence is deterioration from within. If there

is one lesson we can learn from the tragic collapse of great nations overseas, it is this: Tanks, planes, and guns do deadly work but their blows are not one tenth as effective as the fatal virus of hopelessness, insecurity, and despair.

We are determined that it shall not happen here. We want to defend our "way of life." But we cannot do so successfully unless all of us—all three thirds of us—are certain that our "way of life" is worth defending.

Our job is to maintain and to bolster the American standards of decency, humanity, and the democratic pursuit—and attainment—of happiness. In this hour, more than ever before in our history, it is essential that the sick and the needy, the distraught and disheartened, be given renewed faith in themselves, in their fellow citizens, and in their country.

Our community chest campaigns are an indispensable factor in our national defense. They give all elements in the community, all faiths and all creeds, a chance to cooperate in the vital task of plugging the gaps in America's ramparts against poverty, misery, disease, and despair. At this time, beyond all other times, they cannot afford to fail.

The horrors of war throughout the world, the desperate plight of refugees, the appalling magnitude of the problems of humanity are apt to numb us into insensibility regarding the needs at our own doorstep. Yet if we are to preserve the foundation of democracy we cannot relinquish for an instant our efforts to meet our own social problems, while we work as unremittently to build a more generous society which will correct the maladjustments at the root of these problems.

Our dual responsibility for those who are the victims of the war and those who are the victims of our social inadequacies is forcefully expressed by

Margaret Culkin Banning, well known author, and member of the Advisory Council of the National Organization for Public Health Nursing:

If we are to help with the care of refugees from Europe, as every generous American wants to do, we must make very sure that we do not make that care paradoxical by neglecting those who might become or already are American refugees in their own country. There should be no homeless here; no American children who are starving or living in terror; no uncared for American old people wandering from place to place; no American families broken up by circumstances beyond their control or in spite of their constant effort.

If our work for the refugees of Europe is

to be honest and competent, it must begin here by proving that in time of peace we can eliminate and prevent such conditions. So, with great gravity and good faith, let us maintain all those institutions which have the skill and the ability to take care of the needy. This year we shall need them more than ever to set the example of voluntary social work at a time when such work is needed as never before in the history of this country, if our complicated problems are not to be overwhelming. To support your community fund this year is to prove again the strength and policy of democratic America.

It is not too much to say that upon this foundation depends the security of our future.

P. P.

A METHOD OF EVALUATING OUR SERVICE

FOR YEARS the need to measure the quality of public health nursing service has been evident. A few brief studies preceded the *Survey of Public Health Nursing* undertaken by the National Organization for Public Health Nursing in 1933-1934. The Survey gave us new impetus to study quality, perhaps because it had to leave so much untouched and unsaid; and several local public health nursing agencies, the American Red Cross, and the Metropolitan Life Insurance Company have undertaken studies of their staff work along the lines suggested by it. Recently, Dr. Mayhew Derryberry of the U. S. Public Health Service has approached the problem of evaluating the nurse's teaching in the home by new methods. Also, several of the foundations have made intensive studies of the results of the complete public health program, for part of which the public health nurse is responsible. Nevertheless, at every convention and at almost every committee meeting the questions arise: How can we measure the quality of the work of a public health nurse?

How shall we evaluate it in results to the family? We have much information on quantity and cost, but little on evaluating quality and the results of good or poor work.

So the N.O.P.H.N. Committee on Nursing Administration, which is the subcommittee on nursing of the American Public Health Association Committee on Administrative Practice, offered to try out one very elementary, uncomplicated method of evaluating a nurse's work, a method which was limited to recorded facts in one field of service in five agencies. Would the nursing records kept on active tuberculosis cases by staff nurses for more than a year show how well a few accepted criteria of good tuberculosis service were being met? Granted that the nurse knows and does more than she records; granted that not all the necessary clinical information is supplied to her by the physician, clinic, or health department; granted that there will be agency policies peculiar to local situations. Even then, should not a nurse's record give evidence of certain basic services to the patient—

services essential to effective control of tuberculosis and help to the family?

The results of examining the records are reported by the Committee on page 608. They must be considered as a very small part of the whole picture of service rendered the family, and the findings cannot be cited as typical of all agencies. We realize that this is the merest sampling, a first tentative step toward one way of evaluating a nurse's work.

This study suggests another problem to those of us who are responsible for the administrative policies governing staff work. Are we giving enough consideration to the details of professional relationships which affect the work of

our nurses in the homes? Does every nurse know all she needs to know about the diagnosis and condition of her patient and the medical plans for his care, in order to give intelligent service to the family? Are there easy ways for her to get this information? Are the records simple enough to make the essential facts stand out? If these data are not on the records after a year of service, surely the staff nurse cannot be blamed.

It is our hope that this study will suggest a method which may be tried in other nursing services in which there are certain accepted standards for effective work. Won't you tell us what you think about it?

D.D.



CALL TO ACTION

HERE, at last, is a concrete, stirring challenge to us as public health nurses. Please read the report of the industrial nursing survey in Allegheny County, Pennsylvania, undertaken by a committee of the Public Health Nursing Section of the American Public Health Association (page 631.) Some of you heard the report in Pittsburgh last October, but this is a more complete statement. Here the committee, basing its comment on the findings of its survey, states the case for industrial nursing more convincingly than ever before. The Industrial Nursing Section of the National Organization for Public Health Nursing has been concerned about these facts for years. If ever there was a time to act it is now when the health of the worker looms large in the mind of the

public and of the employer as an essential to smooth, uninterrupted production. Why not survey the industrial nursing situation in your own area? What is being done in your state to meet the need for better prepared industrial nurses? What state meetings are being planned to discuss this field of opportunity? What are our lay members doing to interpret to employers what is meant by adequate industrial nursing service?

It is not by coincidence that the N.O.P.H.N. Board of Directors has voted that the next addition to the staff (when the budget permits) will be a consultant service to nurses in industry. We regard this as a public health problem which has gone too long unsolved.

D.D.

How Early Should Dental Care Begin?

By EMORY W. MORRIS, D.D.S.

Important factors in building sound dental health during the antepartum period, infancy, and the preschool period are discussed in the second article of this series

SLOGANS regarding dental care seem to have been the basis for most of the dental education programs conducted in behalf of the public. A number of years ago the dental profession and those working in the health fields eagerly adopted the slogan, "A clean tooth never decays." The implication was that if the individual brushed his teeth long enough and hard enough, dental decay could be prevented. Research soon caught up with us and it was necessary to revise our slogan and say that "A clean, well-fed tooth never decays." Research has again caught up with us and today we realize that dental decay can not be prevented by merely supplying the child with the proper-sized toothbrush and providing him with a diet designed for the sole purpose of growing teeth that will not decay.

In the antepartum program there was once a saying, "For every baby a tooth." We know now that this is false and that it is not necessary for the mother to lose teeth during or after the antepartum period. The nursing group and others responsible for the education of the public are eager for specific information to present to parents and children regarding the prevention of dental decay, and information in the past has been presented in such a manner as to imply that if certain procedures were followed, decay could be prevented. However, with the information which is available today, we can not provide true facts

concerning the cause of dental decay and we have no specific program that will prevent decay of the teeth. Therefore, it behooves all of us to scan with a critical eye the materials that we present, to make sure that they have a sound scientific basis and will not lead the public into a state of false security in regard to dental health.

ANTEPARTUM DENTAL CARE

It is questionable whether we should have a specific antepartum dental program. During the antepartum period the mother should be under the supervision of her physician. The only responsibility of the dentist is the supervision of the mother's dental tissues. The responsibility for the supervision of diet should be left in the hands of the physician with the help of the public health nurse. It should be discussed in relation to the health and well-being of the mother, and not recommended specifically to assure the growth and development of the teeth. During the antepartum period the dentist should recommend:

1. An adequate dental examination (including bite-wing x-ray pictures).
2. The completion of the necessary dental services.

The physician should guide the expectant mother during the antepartum period, delivery, and the postpartum period, and should follow up by keeping the mother informed, through frequent examinations, of the progress of the in-

fant and the necessary changes in his dietary. The physician, with the parents, is responsible for seeing that the child receives his immunizations. And since the dentist rarely has contact with a child before the complete eruption of the deciduous or first teeth—at about two and a half years of age—the physician should refer the child to the dentist for his first visit between two and three years of age.

Every opportunity should be taken by parents to promote the child's health and protect him against disease. Any interference with his normal development, such as childhood diseases accompanied by high fevers, disturbances of the glandular system, and malnutrition may alter the process of enamel formation (calcification).

SOUND GENERAL HEALTH IS VITAL

There are a number of factors, along with the initiation of an early and continuous program of dental and medical care, that assist in the child's growth and development. An adequate diet is first of all necessary. Parents and expectant mothers should be informed that certain foods are more protective than others. An analysis of the content of the foods is often a revelation to them. Physicians, nurses, and dentists can discuss with patients the protective foods which should form the basis around which meals are planned. These include milk, milk products, vegetables and fruits, whole grain cereals and breads, eggs, lean meat, poultry and fish. In certain sections of the country iodized salt and in most areas fish-liver oils should be added to the diets. Charts showing the relative values of the different foods are effective for use in home visits and in discussion groups.*

Another condition necessary for gen-

eral growth and development is that the child's way of living should favor the growth processes. Sufficient sleep, food to meet his needs, sunshine and play, security, and affection are necessary for every child.

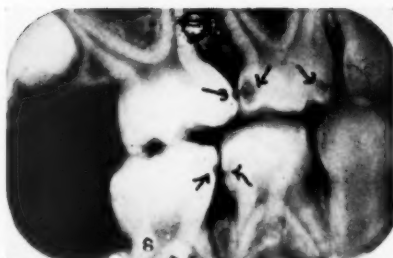
SWEETS ARE RELATED TO CARIES

✦ The use of candy, free sugar, jams, jellies, pastries, chewing gum, and pop or soda has no place in the diet and is associated with dental decay. An adequate diet will contain a sufficient amount of foods rich in carbohydrates without the additions of large amounts in concentrated form. It is not necessary for the small child to use sugar on his cereal and fruits. This habit undoubtedly has its origin in his early years. Many times sugar is used on the cereal and fruits to encourage him to eat them, or more often, sugar is added because the adult prefers it that way and assumes that the child will, too. Then as he grows older the child continues to increase the intake of sugar merely as a habit. Research workers agree that there is a relationship between candy or the excessive use of sugar and dental caries. Popcorn, fruit, and nuts are easily substituted for candy. The sale of candy by school organizations and others is being replaced by the sale of fruit, popcorn, and sandwiches.

Eruption* of the deciduous teeth usually begins at about six months of age. The eruption of the teeth is a normal process and usually is not accompanied by any disturbances. Many children like to bite on hard objects when the teeth are coming through the gums. Hard crusts of bread, toast, large chicken bones (that have been cooked, and the meat, bony projections, and gristle removed) are suitable material on which a child can bite. Eruption of

*Charts used effectively in one agency were described and reproduced in an article in this magazine, "Helping Families on Small Food Budgets," by Anna dePlanter Bowes, October 1939, p. 532.

*Morrey, Lon W. Teeth, Health and Appearance. The Bureau of Public Relations American Dental Association, 212 East Superior Street, Chicago, 1940, p. 15.



X-ray pictures assist in detecting early dental caries (child 4 years old). Arrows point to decay in between the teeth that might go undiscovered for some time without the aid of the x-ray

teeth varies, but in general the lower teeth erupt before the upper teeth.

Childhood habits such as thumb-sucking, lip-biting, and improper posture habits while the child is awake and asleep may have some influence on the position of the teeth and the shape of the jaws. Public health nurses can inform parents that the correction of these habits should be attempted if possible by removal of the physical or emotional underlying causes, without calling the child's attention to the undesirable habit.

The child from 16 to 24 months of age tries to follow and repeat the actions or words of others. At two to four years he is very receptive to new ideas and wants to do things for himself. This is the period in which he needs help in initiating his home care, such as washing his own face and hands and brushing his teeth. Equipment can easily be provided to enable him to do these things himself—such as a substantial footstool with one or more steps and a mirror hung low. An opportunity should also be given the child at this time to become acquainted with the dentist and his office if only for a brief visit the first time.

DEFECTS HIGH IN YOUNG CHILDREN

The child's first visit to the dentist must be a pleasant one if the maximum amount of cooperation is expected from him. Approximately 50 percent of children from two to three years of age are found to have dental defects. The pre-

ventive program in dentistry as we know it today consists mainly of the early discovery and correction of these defects. One way the dentist has of detecting decay early is the use of the bite-wing x-ray picture. Decay between the teeth can be found much earlier by its use than by mirror and explorer examination. In order to be a preventive measure this must be followed up by having the child scheduled for a recheck examination. The responsibility of providing a program for continuous dental care belongs to the parents and the dentist. This is one way, we know, that will prevent the premature loss of teeth.

There are still many parents who do not realize the value of preserving the deciduous or baby teeth. The dentist's interest is not in the tooth alone but in the effect its neglect, infection, or loss may have on the person's general growth and development. These deciduous teeth should remain with the child from six to thirteen years of age. The loss of one or more may cause considerable difficulty in chewing food and also may cause a shifting of the remaining teeth, making difficult the eruption of some of the permanent teeth.

USE LAY GROUPS IN PROGRAM

Preschool children are a much more difficult group to supervise than the school group. We can not depend upon the physician, the nurse, and the dentist alone to get the preschool child under dental supervision. Lay groups* such

as mothers' clubs, parent-teacher groups, community health committees, and township service committees made up of key people in a community have been organized in many places and are functioning effectively in all fields of the health program. They assist in making contacts with individual families and with organizations, helping them to see the needs for dental and medical care. In one county in Michigan, the public health nurses have utilized lay groups and local professional persons to quite a high degree. In the dental program the number of children up to eleven years of age under dental supervision is twice that of last year. This was not accomplished by any increase in personnel but by the coöperation of the dental profession and nurses, who found that they had problems in common and attempted to solve them together. The

teacher may be very helpful to the preschool program by creating interest in dental health and asking the mothers of preschool children to participate in the program, for many families with children in school also have preschool children at home.

The nurses are getting a good response from mothers of kindergarten children in group discussions, in which a physician and a dentist are invited to discuss the medical and dental program. A local physician or dentist will be glad to participate in a discussion with mothers' clubs, parent-teacher associations, and other groups, if he is given time to make his plans. The dentist, nurse, physician, and key people of a community can accomplish a great deal if they are brought together and the individual problems are made community problems.

*Morris, Emory W. "The Utilization of Community Resources in the Health Program." *Journal of the American Dental Association*, March 1939, p. 493.

EDITOR'S NOTE: This is the second in a series of articles contributed by the Dental Health Education Committee of the American Dental Association.

THE HEALTH EXAMINATION

AN ILLUSTRATED pamphlet on "The Health Examination" has been prepared by the Nursing Department of the Community Service Society of New York, for the use of public health nurses in their family health service. Through a series of 30 pictures the steps in a complete examination are shown—including the interpretation by the nurse of its purpose, the tests made by nurse or laboratory technician, the taking of the medical history, the physical examination by the physician, the explanation of the findings, and the plans for follow up of recommendations. This invaluable pamphlet is available from the Society, 105 East 22 Street, New York, N. Y., for 25 cents plus postage.



The Wassermann test

A test for syphilis should be a part of every complete health examination

Citizen Committees in Official Agencies

By EVELYN K. DAVIS

The use of the individual citizen as interpreter of the public health program is the principle underlying the growth of the citizen committees in tax-supported agencies

IF a Gallup poll were to be taken on what the average citizen knows about public health in his own community it would probably disclose an abysmal ignorance. Most people do not know what percent of their tax dollar is going to the promotion of health and the prevention of disease in their community. They do not know what amount authorities agree should be spent for adequate protection. They do not know what constitutes professional training and experience for health officers, public health engineers, and public health nurses. Ask any citizen on the street just what his community has in the way of a health department—what its services are and how he is making use of it. You will be surprised at his answers.

Health officials are realizing more and more that public understanding and support are necessary for the continuance of adequate public health programs, for the maintenance of high standards of personnel appointments, and for the use of the health department's services. Many methods are used for interpreting the health program to the public—newspapers, radio, posters, charts, exhibits, and other media. One method which is increasingly found effective is the use of a committee of citizens closely affiliated with the health program itself, to act as personal interpreters to the rest of the community. More and more local health departments are using such committees. They are calling them advisory committee, ad-

visory council, citizens' committee, health committee, or coordinating committee. The name is immaterial. The purpose is the same.

The layman is not often vitally concerned with the health program unless he is participating in it. Laymen read newspaper stories and are moved at the moment about the health situation. They see a chart depicting the death rate from tuberculosis, diphtheria, and other diseases, and feel that these are problems in which they should be concerned. But it is the woman who is responsible for the maintenance of a loan closet in her town, and the man who is a member of a committee which meets regularly with the health officer and the public health nurse, who really do something about the health work in the community.

INFORMED LAYMAN SEES THE NEED

Laymen who are informed can readily see how important it is to them and their families to have safe water, adequate sanitation, a safe milk and food supply, and the protection of their children from preventable communicable disease. They can see the saving in present and future taxes if tuberculosis is prevented, if fewer mothers die in childbirth, if more wage earners are kept on the job, if fewer epidemics occur. They are also interested in helping others, and the distress due to sickness and ill health makes them want to help. They can give real assistance to the personnel of the health department, if they are effectively used.

Some suggestions in regard to the use of laymen in citizen committees have been gathered by the author from a survey of existing committees and from many field visits and conferences. It is recognized that no one pattern will fit every community. Such things as distances, transportation facilities, economic status of committee members, and types of organized lay groups play a part in determining what type of committee is best fitted for a particular community.

These suggestions are presented both to the professional personnel of the health department and to lay people who are contemplating organizing a citizen's committee, because the effectiveness of such a committee depends on both groups working closely together to further the program.

Each group has definite responsibilities. The professional worker needs a conviction of the value of lay committees and a recognition that time must be spent in order to help them carry out their work effectively. He must be willing to give that time. He must be willing to delegate things for the committee to do. He must be ready to inform the layman about the program, explaining it at committee meetings and being ready at all times to take the layman into his confidence about the work.

SHALL WE HAVE A COMMITTEE?

There are various points of view regarding the organization of lay committees. Some professional staffs feel that they do not want to have laymen advising them on their programs. Such a committee is not, however, to advise the worker on his professional job, but to assist with nonprofessional activities and to advise on community problems that the members as citizens know rather intimately. They are a testing ground for the health officer. Their most important job is interpreting the program.

Perhaps a skepticism about lay advisory committees has arisen because the

name was "advisory" rather than "interpretive" committee. However, shouldn't we recognize that all of us, no matter in which field we are working, benefit greatly by advice and assistance from people in a different field and different parts of our community life?

Sometimes the professional hesitates to have a lay committee because he fears it will run away with the program. This occurs sometimes when there has been an unwise selection of committee members and lack of careful guidance from the professional worker. Actually, however, with all the various demands on the laymen these days it is hard to get them to take enough responsibility.

One objection to the organization of a lay committee is that it takes too much time. "There are so many other things which need to be done that this project will have to be put off until later." Certainly a committee does take time, but after all, the health work in a community is supported by its citizens. Whether the money comes from federal, state, or local funds, the budget depends upon the approval and vote of these citizens. Therefore, the understanding of citizens is essential for continuance of the program. The health department needs many things—more staff, more office space, money for necessary equipment. If someone can work for these, more time of the health department staff can be spent in the professional part of the job.

No matter how impersonal the professional is in asking for larger budgets for his own department, there is inevitably in the mind of the appropriating body the conviction that after all the professional is naturally convinced of the value of his work and wants more money to carry on his own job. It is much more effective to have someone else say, "What an excellent program the health department is carrying on, and how vitally it is needed in the community."

THE LAY MEMBER HAS A REAL TASK

The layman on his part has definite responsibilities for making a committee really *work*. If he agrees to serve on a committee, he should take that job seriously. He should come to meetings, be on time, carry out a job which he has agreed to do, and take a definite responsibility as a committee member.

Too frequently professional workers do not think that lay committees are of any value because they never can get them to work. Just as soon as the professional has delegated a job to the layman to do, something else seems to interfere and the worker has to do it himself. In these days, the layman has to be responsible for budgeting his time, and for agreeing to do only those things that he can really do. He should come with an open mind, a desire to learn, and a willingness to study the program of the health department.

Having convinced ourselves as professional workers that we believe in a lay committee and that we want to have an effective one, and having convinced ourselves as laymen that this is an important activity in which we can serve our community—how do we go about organizing the best committee to suit our own particular community needs?

ORGANIZING A COMMITTEE

The first point in developing any committee program is to go slowly. Someone said it is harder to "unorganize" a poor committee than to organize a good one. It is important for new workers to learn something about the problems of the community before a committee is organized. The question is often asked: "When should we start one?" It is not possible to say a year, or a month, or two years, but a health worker should have the feeling of knowing the community before the membership of the committee is first called upon to organize.

Let us imagine a specific situation

and see what might be done in organizing a committee. Supposing a new health unit is set up in a county covering a large area geographically, and having three or four large towns besides the county seat. The county commissioners have voted the necessary money for a full-time unit, but they are not really very well informed as to just what this unit will do. The medical profession is behind the development of the unit and is anxious to cooperate. There are also several lay organizations which have been active in health work. The Red Cross and the tuberculosis association have carried on health programs in the county. The parent-teacher association has had a summer round-up, and the American Legion child welfare committee has assisted in some corrections of defects. The personnel of the health department is composed of people who are strangers to this particular county.

Potential membership

The first step might be for every member of the health department staff to make a list of individuals with whom they come in contact, who might be of help in developing a committee. The health officer will take occasion to call upon the presidents of lay organizations in the county, such as the tuberculosis association, the Red Cross, the parent-teacher association, the American Legion, the farm bureau, and the men's civic clubs. Ministers, the county judge, and the county superintendent of schools will know some of the outstanding people.

The public health nurse will find people in her mothers' classes and through the schools in various parts of the county, who will be potential committee members.

Some people advise always getting the outstanding citizens of the community on the committee. To the writer this seems unwise. After all, there are only a few outstanding citizens in any com-

munity, and if every organization uses those citizens they have so much to do that they cannot give time and interest to the work of the health department.

The thing to do is to get the suggestions of these outstanding citizens and their help in finding other laymen who will have time and interest in the field of public health. A major qualification for a committee member is *time*—time to attend meetings, time to give thought, and time really to work in the program.

Size

How large should a committee be? It should be large enough to be representative of the area that the health department serves and also large enough to get the work done. But too large a committee is hard to use effectively. The average is from 15 to 30 members. Too small a committee is often drawn from one group and too large a committee is difficult to keep interested.

Representation

A committee which is to render a community service should represent all groups and all interests. It should include men and women; maturity and youth. It should have representatives from county medical and dental societies, from various lay organizations, from labor organizations, from various towns in the community. It should include a county commissioner and the county superintendent of schools. If the county serves many towns and representation from each town would make the committee too large, the county can be divided into three, four, or five sections, with representation from each area.

The first meeting

Now we are ready to start organizing. We have a list of names of people who have been suggested by various individuals in the community—people whom the staff have personally visited and who

expressed interest. Everything is ready for the first meeting. A community may have a steering committee, say three or five carefully picked people, who will invite the prospective members to attend a meeting. Another community may ask a person well respected and known, such as the county judge, to invite the group together. Still another community may obtain a temporary chairman, who is willing to call the people together. In one place, the health officer sent a letter to individuals in the community inviting them to come to the meeting.

This first meeting should be very carefully planned. It should include a presentation of what the health program is doing in the community—not in great detail, but some of the high spots—with an explanation of who the personnel of the department are and what they are doing. The use of graphs and illustrative material, and possibly the distribution of something in mimeographed form to be studied later at leisure, are most helpful. Then some speaker will present the importance of having community understanding of the program, and the need of organizing a representative committee to work with the health department personnel.

Discussion about such a committee will take place from the floor. A temporary chairman may then be appointed and two subcommittees formed. One committee will draw up some rules to be adopted at a subsequent meeting. The other, a nominating committee, will present at a later meeting a slate for committee members and a slate for committee officers.

BYLAWS

The formulation of a simple set of bylaws or rules for the committee to adopt is important. This gives it some permanent form of organization. Too frequently a good committee has slipped away because it did not have any form

of organization and the members did not have any responsibility for keeping it going.

In the *Board Members' Manual*,* there is a suggested form for committee rules (page 153), and various state health departments have worked out suggested bylaws.

Some points to consider in the bylaws are suggested here:

1. The name of the committee should be stated. Various organizations have used various names, as for example, the health council of _____ county, the county health committee, the advisory health committee, or the advisory committee.

2. The objects of the committee should be defined. In the *Board Members' Manual*, the objects are listed on page 153 as follows:

To assist in interpreting the public health program to the community in order to have it adequately supported and used.

To assist in maintaining high standards of service.

To assist in developing a coöperative program with all of the public health agencies in the community.

3. The membership of the committee should be elected to serve in such a way that only one third or one fifth or one half of the membership terms will expire each year. To illustrate, suppose the new committee is to consist of 21 members. The bylaws might read as follows:

We shall have a committee of 21 members, 7 of whom will be elected for a one-year term, 7 of whom will be elected for a two-year term, and 7 of whom will be elected for a three-year term. At the next annual meeting following the adoption of the constitution, the 7 whose terms have expired may be re-elected for a three-year term. Next year those who had been elected at the beginning

to serve two years may be re-elected for a three-year term.

And then the rotation has started. Some organizations limit the number of terms the committee member may be elected to serve. For example, a committee member may be elected for a three-year term, and re-elected one or more times; but he may not be re-elected following service of, say, nine years unless there is a year between the expiration of the term and re-election.

The important thing in developing a committee is that it shall be a fluctuating group, which is not made up of the same members continuously year after year. We need the different points of view of different groups and individuals. Moreover, service on a committee is one way of educating various people about the work.

4. The officers of the committee are usually the chairman or president; the vice-chairman or vice-president; the secretary; and the treasurer (if the committee is handling any funds).

The officers are usually elected for a definite number of years, and a clause is often inserted in the bylaws limiting the number of terms they may serve. Here again, there is need to rotate offices among various members of the committee so as to spread the responsibility and increase the interest. The officers should be drawn from the lay membership of the committee. Sometimes a professional staff member of the health department may serve as secretary; but the more the responsibility is put upon the members of the committee themselves, the greater their interest will be. The chairman should be a person who has qualities of leadership, who has ability to bring out discussion, who is interested in his community, and who has the respect and backing of the people. The vice-chairman serves in the absence of the chairman and frequently is elected chairman after his

*National Organization for Public Health Nursing. *Board Members' Manual*. The Macmillan Company, New York, 1937.

experience in working with the chairman for a year or so.

SUBCOMMITTEES

Subcommittees are appointed by the chairman and approved by the rest of the health committee, to carry on a specific part of the work. The membership of all these subcommittees may be drawn from the health committee, or from people outside the committee. The chairman, however, is always a member of the health committee. The nominating committee which presents the slate of the members and officers to the membership for election at each annual meeting is often elected by the membership, just as the officers and members of the health committee are elected.

Large health departments frequently have subcommittees working with their various divisions; for example, a committee working with the public health nursing director and her staff, to be known as the nursing committee; a committee working with the public health engineer in the division of sanitation; and perhaps a committee on vital statistics. It is important to bring into these committees people who will be helpful and who represent other organizations with which the various divisions will be working.

Another group of subcommittees might be called committees on program, as for example, a committee interested in work with the crippled child; a committee on eye health, whose membership represents various organizations and individuals working for the prevention of blindness; a committee on tuberculosis; or a committee on maternity and child health.

DISTRICT COMMITTEES

District committees in addition to the large group are needed in a countywide or citywide program. The chairmen of these district committees are members of the county or city committee and each

of them in turn will organize in his town or his area a district committee of people who will be directly helpful in carrying out work in that area.

These district committees are often the groups that work closely with the public health nurse. They frequently maintain and furnish a loan closet which the nurse uses for supplies needed in her work. Sometimes these committees supplement the health department's budget by paying for an office for the nurse, transportation, or telephone service. Where it is not possible to have a local office, sometimes the chairman of this district committee takes messages for the nurse when she is not in the area.

Members of this committee may help the nurse in the child health conferences. Frequently in places where committees have been well organized, the health officer and the nurse merely notify the committee that a conference is to be held at a certain time and the members prepare the room, send out the notices, arrange for publicity in the paper, and are on hand to assist with nonprofessional tasks during the conference itself.

Motor service is often handled by the district committees, who transport patients to clinics or hospitals or conferences when it is impossible for them to get there in any other way. Certainly the valuable time of the professional worker should not be spent in transporting patients. This motor service, however, is not successful unless the committee members take it as a serious responsibility. If the nurse has to call innumerable people in the town to have a car available when needed she might just as well do it herself. The most successful motor service is in places where one group, such as a church group or a women's club, makes that its major activity and always has a car available when needed. If the responsibility is spread among a sufficient number in a group, it does not become a hardship for anyone.

OTHER ACTIVITIES

Other activities which have been undertaken effectively by local committees include the following:

1. The making of demonstration materials which the health officer, public health nurse, and others can use in their teaching programs. A public health engineer recently used the manual training class in one of the high schools to assist him in making demonstration materials such as models of a sanitary privy and a screen door. This was also an education for the boys. Public health nurses used the committee to make demonstration material for mothers' classes.

2. The placing of books on health in the local library or in the health center.

3. The organization of classes, such as home nursing classes, mothers' clubs, and fathers' groups.

4. The referral of health problems to the health department. This involves being aware of health needs of the people and seeing that they get in touch with the health department for various services which it can render.

5. The raising of funds for medical relief. In communities where there are no social agencies able to assume responsibility for medical treatment and the correction of defects, the committee may raise a small loan fund to be used at the discretion of the health officer and public health nurse when needed medical expenses cannot be met by the patients themselves.

6. Assistance in preparing hot lunches in the schools.

7. Assistance, under the careful supervision of the health department personnel, in the making of surveys, such as a survey of housing—a factor that contributes so much to poor health in a community—or a survey of the school buildings and environment in order to see whether there is proper lighting, heat, and sanitation. (Various outlines to be used as guides for a survey of school

conditions are available. One that may be obtained from state tuberculosis associations is entitled "Healthful School Living.")

A PUBLICITY PROGRAM

One important function of the health committee is carrying on a publicity program. If the health department is in a large city with a specialist in public health education on the staff, the committee members may be used under his direction in various capacities. Where there are no experts with this knowledge and ability on the staff, a subcommittee on publicity is extremely valuable, to help the health officer present his program to the public. Membership on this committee should include people with real ability in the publicity line, such as representatives from the newspaper and advertising field, good speakers, and a person with artistic ability or perhaps someone with a camera hobby.

Preparation of material for newspapers can be done by a committee member. Of course, everything is checked by the health officer to see that it is correct in all details, but often a lay person can put professional material into nontechnical terms that will make it of greater interest to the reading public.

The making of posters and interpretation of statistics in charts can be done by the publicity committee. Some committees have a poster contest or an essay contest for school children, on what the health department is doing.

Working up a speakers' bureau is an activity for the publicity committee. Contact is made with program chairmen of local clubs to arrange at least one meeting on health during the coming year. The committee can often make the arrangements for a talk by the health officer, public health nurse, or public health engineer. Also, some of the committee members can be used as speakers, if the personnel of the health department

will take time to give them correct factual data.

With the growing interest in photography and motion pictures, some local committee member may be used to take good photographs for use in exhibits, or for the making of a moving picture.

EDUCATION OF COMMITTEE MEMBERS

The planning of an educational program for the committee is essential. When the committee is organized, or when new members are elected, time should be taken to orient the members to the work of the health department and of the committee. Some organizations have worked out a small and compact handbook for each committee member. These can be in inexpensive mimeographed form, and will answer certain questions about the health program. If the committee has no money to mimeograph such a handbook, a high-school class or the chamber of commerce will often do the job.

Some committees have a subcommittee called the education committee or study committee, which is responsible for the introduction of new members to the work and for planning some educational material at board meetings, such as an outside speaker on some subject or a special report of a meeting. When officials from the state department of health, or national visitors from the health field are in the community it is valuable to have them visit the lay committee.

PLAN MEETINGS CAREFULLY

Meetings of the committee should be held regularly. Sometimes these are four times a year if the committee is serving a countywide area where transportation is difficult at certain seasons. The important thing is to have a definite time, place, and hour set for the meetings so that committee members can plan for them.

The meeting place is usually the

county seat or some central place where everybody can come. Sometimes a committee rotates its meetings among various towns in order to give the members a better knowledge of their county problems.

The regular meetings of the committee should be carefully planned. Notices should be sent in advance. Some committees send with the notices data on one or two points that are going to be discussed. This frequently stimulates attendance.

The agenda should be worked out carefully by the chairman of the committee and the health officer. The meeting should include good reports of subcommittees and district committees. The reports of the chairmen of various district committees on what they are doing frequently act as a stimulus to other district committees that have not been very active. One advisory committee had its whole year's meetings planned in advance and sent a notice to each committee member so that he would know what topic was to be discussed. Part of the meeting was given over to necessary business and part to some special program. In addition to its primary purpose of getting the work done, the meeting should be educational, and the ability of the chairman to bring out discussion is very important in making meetings a success.

The most important part of any committee meeting is the report which the professional staff makes to the lay group. At a meeting of the county committee of the whole health department, reports should be made by the health officer, the supervising nurse, and the engineer. For the committee working with the nurse alone in a town or district, her report is the most important factor in stimulating the group and keeping it up to date on the program.

Successful reports depend on the ability of professional workers to help the layman visualize just what the program

is. Long lists of statistics—figures showing numbers of visits, cases, immunizations, and clinic attendance—are not very interesting unless they are translated into terms of an actual family, a certain child, or a concrete health problem. Putting figures on the blackboard helps. Sometimes statistics are mimeographed and given out, and then an interpretive report presented showing some of the community health problems, the type of service the professional worker is giving, and the unmet needs in the community.

LAY-PROFESSIONAL RELATIONSHIP

The question is often asked, "What is the relationship between the professional staff of the health department and the health committee?" Do the staff take the leadership in developing the program, or do they sit back and let the committee do it all?

The work is a joint responsibility. It is true that the more the committee has a feeling of responsibility, the greater its interest will be. The most successful committees are those in which the health officer and the public health nurse are the inspiration behind the scenes, delegating things for the committee to do, and giving the members a feeling of satisfaction in carrying out a particular job.

One health officer said that he welcomed a committee that was full of ideas and suggestions. Sometimes these were not practical at the time, but they were a good stimulus to him and kept him from getting into a rut and constantly thinking only in terms of the job at hand.

Professional workers are, of course, *ex officio* members of the committee and of all subcommittees, and they attend all meetings and stay throughout the discussions. We need both points of view in our program.

Many state health departments are recognizing the importance of developing local lay committees and have prepared

material which is helpful for their local health departments. The National Organization for Public Health Nursing* has assembled some of this material in a loan folder, which is available to its members for the mailing cost only.

STATE HEALTH DEPARTMENTS

Interesting examples of things the states are doing can be cited. For years Minnesota has promoted public health nursing committees for its local programs and has prepared a manual which is revised each year, containing data for the local nursing committees. This past year, the local committees studied themselves, following a comprehensive outline, and listed their activities. At the spring meeting of the Minnesota State Department of Health, an interesting report was made on these studies.

Utah has a mimeographed pamphlet entitled "Community Health Organizations," which outlines the reasons for having health councils and how to organize them. Iowa has a pamphlet called "Manual of Information for Public Health Nursing Committees." Colorado likewise has a program for the development of public health nursing committees and uses a mimeographed pamphlet for assistance.

Florida has organized a State-Wide Public Health Committee, to promote local committees in every county in Florida,** carrying out the recommendation made in a study by The American Public Health Association. A "Manual for Florida State-Wide Public Health Committee" has recently been published.

Texas through its State Department of Health is assisting in promoting three kinds of county committees: (1) a county health committee where there is a full-time county or district health unit (2) a committee for the nurse who

*50 West 50 Street, New York, N.Y.

**See "Florida's Citizen Committees," by Jean Henderson, PUBLIC HEALTH NURSING, March 1940, p. 166.

is working alone and is not part of a county health unit (3) a committee where there is no public health service. The Department is working on a committee manual.

Idaho has organized a state advisory committee for the Bureau of Maternal and Child Health and Crippled Children and hopes to use its members to help promote local county health committees. Other states have also done a great deal in the promotion of such programs.

COMMITTEES IN CITIES

It would be impossible to summarize the things that are being done in various committee activities in cities. Several city health departments have recently developed public health nursing committees, such as the committee of the Division of Public Health Nursing in the New York City Department of Health. The health departments in Washington, D.C., and Louisville, Kentucky, have health committees representing the lay group. St. Louis, Missouri, has probably the oldest city public health nursing committee, representing

lay people who work in the nursing program of the Health Department.

To summarize, successful committee organization depends on several things: First, there must be a conviction by the health officer, public health engineer, public health nurse, clerk, and all the professional staff that the layman can be an effective assistant, and recognition by the layman that here is a challenging opportunity to serve in a program of vital concern to every citizen, himself included. Second, there must be a careful selection of members. Third, there should be some definite form of organization with officers and bylaws. Fourth, a plan for keeping the layman informed is essential. Fifth, there must be activities outlined for him and a willingness to let him do the work.

Much is said these days about democracy and the democratic principles. A representative committee organized for a community service and working as partners with the professional staff is practicing the democratic principle in a very concrete way.

National Tuberculosis Association

WHERE SHALL we lay our chief emphasis today in the tuberculosis control program? This seemed to be the question which emerged most frequently in the sessions of the thirty-sixth annual meeting of the National Tuberculosis Association, in Cleveland, Ohio, June 3 to 6, 1940. Various measures in the strategy of the campaign against tuberculosis were discussed in the Administrative Section.

What can we do to increase resistance to the disease, through heredity, specific immunity, and a favorable environment? Dr. Allen W. Freeman of Balti-

more, Maryland, in discussing this subject, said that all health workers are vitally concerned with promoting measures of social betterment which will help to build up the general health and thus develop physical resistance to tuberculosis. He concluded, however, that our "unique opportunity is in the control of infection." And this, indeed, was the keynote of the meeting.

"Since it is only the tubercle bacillus that causes tuberculosis," said Dr. J. Arthur Myers of Minneapolis, "we should direct our activities wholly toward the control of this organism."

Pointing to the dramatic results obtained by the veterinarians in completely eradicating tuberculosis in cattle in certain areas by tuberculin testing and the destruction of all positive reactors, thus eliminating the source of contagion, Dr. Myers emphasized that similar results in human beings could be obtained by the strict isolation of patients with open cases of the disease. He outlined a ten-point program which would have as its aim "the creation of an environment free from tubercle bacilli." This program included the securing of adequate hospital facilities for patients in a communicable stage of the disease, the isolation and adequate treatment of all patients "who have tuberculosis of the lungs which is already or soon will be contagious," isolation technique in sanatoria and hospitals, and the education of patients on the importance of periodic reexamination throughout life.

Similarly, Dr. Edward S. Godfrey of New York, in an outline of principles which should guide the programs of tuberculosis associations in the light of the epidemiology of tuberculosis, stressed the need for ample provision of hospital beds for the segregation of the active, open cases, and the necessity for a reduction of economic difficulties which often deter these patients from entering a hospital. Dr. Godfrey said, "The distribution of hospital beds and the adjusting of existing facilities will require the aid of both state and federal government if the need for them rather than the capacity to erect and maintain them is kept as a primary consideration." He also called attention to the need for a change of emphasis in case-finding with more concentrated effort on the examination of adult contacts of known cases.

The big annual dinner on the opening night, was, as usual, a gala affair which was attended by all those participating in the meeting—physicians, executives

of tuberculosis associations, and nurses.

The clinic on Nursing in Tuberculosis, held at the Lowman Memorial Pavilion, City Hospital, on June 5, was so popular that the program was repeated twice during the afternoon to accommodate the nurses attending. The importance of good nursing care of tuberculous patients and the necessity for having an adequate ratio of nurses to patients in order to make good care possible was emphasized in discussions by Bess M. Ellison, clinical instructor in the Lowman Memorial Pavilion, and Blanche Davis, director of nurses, at Sunny Acres Sanatorium, Warrensville, Ohio. "Nursing in the Home from the Public Health Point of View," was discussed by one of the well known authorities in this field, Fannie B. Eshleman, supervisor of nurses, Henry Phipps Institute, Philadelphia.

The need for more clinical experience in communicable disease nursing in the schools of nursing was brought out by Kathryn Helm, superintendent of nurses in Franklin County Sanatorium, Columbus, Ohio. Miss Helm said that over a third of the students in schools of nursing in the United States have had no experience in either communicable disease nursing or tuberculosis nursing. She discussed the need of building up the nursing standards and educational programs of sanatoria to the point where students can be accepted with safety to themselves, and offered sound educational experience.

The very real interest of nurses in the problem of tuberculosis was manifest in the enthusiastic response to this session, which was arranged by the local nurses of Cleveland. Nurses were gratified to learn that as a result of their request for a place on the N.T.A. program at San Antonio, Texas, next year, Esta H. McNett, supervisor of Lowman Memorial Pavilion, has been appointed a member of the program committee for 1941.

P. P.

Follow-Up Care of the Premature Baby

By HELEN ELIZABETH HESTAD, R.N.

This plan for follow-up care of premature infants grew out of studies made in a special clinic conducted by the hospital and the visiting nurse association

A SPECIAL clinic for premature infants was tried experimentally by the Minneapolis General Hospital with the coöperation of the Community Health Service for a period of eight months in 1938-1939. Some of the things we learned, our reason for and against a special clinic for premature babies, and our present plan for the babies may be of interest to agencies confronted with the same problem.

Upon discharge from the hospital, these babies had previously been referred to the regular well baby conferences conducted by the Community Health Service, which is a combination of the Infant Welfare Society and the Visiting Nurse Association of Minneapolis. A special schedule of home visits was carried out by the visiting nurses, but the conference physician's treatment of the infant did not particularly take into account the fact that the baby was premature.

Early in 1938 the chief of pediatrics of the hospital decided that he would like to refer the premature infants to a clinic where their special problems would be less likely to be overlooked, and where certain studies could be made. One purpose was the devising of a formula for the premature baby that could be recommended to rural physicians of Minnesota and adjoining states when breast milk was not available. The other was an investigation as to the value of giving iron medications or foods high in iron to premature babies.

This special clinic had certain values.

The physician was always aware that he was dealing with a premature baby and made special notations as to its growth, development, and early achievements. Several formulas were worked out which proved to be very successful. Although the variations in hemoglobin were not always accounted for, it was found that the addition of certain foods and medications to the diet tended to prevent the babies from slipping into a secondary anemia. This anemia, which frequently occurs between the fifth and eighth week and again between the eighth and ninth month, is considered to be more or less physiological.

The mothers attended regularly, the average attendance being 12 out of every 15 appointments. A number of fathers also attended. Because of their common problems, the parents were particularly interested in each other's babies, and the clinic became a social as well as a medical center.

DRAWBACKS TO SPECIAL CLINIC

There were, however, two rather important drawbacks. One was the difficulty in arranging a satisfactory plan for nursing personnel at the clinic. In the general infant and preschool conferences, the plan is to have a mother attend the conference on the day when the nurse from her district is there. This was impossible to arrange for the special clinic. As a result, one nurse saw the mother at the conference and another at home, with a resulting decrease of effectiveness in both places. Another

difficulty was transportation. It did not seem advisable to continue having mothers carry their babies for a considerable distance on crowded street cars, and besides there was always the matter of cost.

For these reasons, and because the special studies have been completed, the babies have been returned to the regular conferences.

The group studied included 79 infants, which is large enough to suggest some trends. Some of the findings of the studies are summarized briefly here:

If we look at the 79 women as a group, the first impression that stands out is the fact that they did not present the same appearance of health as other groups of mothers. Of 16 patients attending our own antepartum clinics, 5 had hemoglobins of less than 60 percent, 2 had cardiac disabilities, 3 had hypertension, 1 tuberculosis, and 1 syphilis.

About one third of the number were first pregnancies. A third of the mothers had had less than two-year intervals between previous pregnancies.

Although the number is small it is of interest to note that 13 of the 25 first pregnancies were the result of premarital intercourse, resulting in forced marriages.

More than a third of the mothers had had previous premature babies.

The group as a whole was composed of younger women, over half being under 25 years of age. The age range was from 16 to 41 years.

About one sixth of these mothers had had no antepartum care. Slightly over a third did not receive care until the third trimester of pregnancy. Another third had care during the second trimester. Only a sixth had care beginning in the first trimester of pregnancy.

The present plan for home and conference care has been worked out after several conferences of all the people whose program touches the care of the premature baby. This group includes

the chief of pediatrics at the Minneapolis General Hospital, the nursing supervisors, the social service worker and milk laboratory nutritionist from the hospital, and the supervisor of child health from the Community Health Service.

THE PRESENT PLAN FOR CARE

The first nursing visit is made within 48 hours after the mother leaves the hospital on about the ninth day postpartum. The hospital gives the visiting nurse service significant information about each mother in writing, including any complication that occurred while she was in the hospital, her condition on discharge, the doctor's orders, and whether there are any contraindications to breast feeding.

The nursing visit includes the usual observations, demonstrations, and instructions pertinent to postpartum care. Since the mother needs special attention, it is important that she be given a simple explanation of the physiology of normal involution, and every possible assistance in carrying out the physician's orders, including such special examinations or studies as are deemed necessary to prevent, if possible, another pregnancy terminating in premature birth. Emphasis is placed on the general hygiene of the postpartum period, so that insofar as possible optimal conditions will prevail for carrying out treatment for the mother and maintaining and increasing the supply of breast milk for the baby.

Unless contraindicated, manual breast expression is demonstrated, and instruction given as to the preservation of milk and its transportation to the hospital for the baby. It is interesting to note the pride with which the expressed milk is presented to the milk laboratory. The nutrition worker and nurses are careful to praise the mothers, and especially the fathers—who often are the purveyors of milk—even if just a few ounces are contributed.

When the baby weighs 2400 grams

(5 lb. 5 oz.) the mother is instructed to come to the hospital once daily for a week to nurse the baby, bringing with her the milk expressed from the other feedings throughout the day. A special room is used for this purpose. The mother is provided with a clean gown and mask. She is taught to wash her hands, and shown how to handle the baby and help him adjust to the nursing experience. During this week, the social worker has an interview with the mother to inquire as to possible infection in the family which might prevent the baby's discharge. If there is an illness the social worker asks the Community Health Service nurse to make a visit before the baby is sent home.

If all is well, the baby goes home soon after he has reached 2500 grams (5 lbs. 8 oz.). The Community Health Service nurse is notified and given essential information and orders in regard to matters such as weight, feeding, type of bath, special foods, and medications. The mother is told that the nurse will visit her and help her with the care of the baby. This home visit is made the day after the baby leaves the hospital and includes the usual observations, demonstrations, and instructions pertinent to the care of a well baby. Since this baby needs special care, all details

of the feeding schedule are emphasized, as well as the importance of warmth and cleanliness, prevention of infection, and medical supervision.

The mother is invited to bring the baby to the well baby conference in her neighborhood as soon as possible and an appointment is given. The regular conference procedure is followed, with a few exceptions. Hemoglobin tests are made monthly on the babies under one year of age. Special feedings and medications are ordered, and the records are marked to indicate that the patient is a premature infant.

A tickler card system is used to designate all conference and home visits; and the ticklers of the premature infants are marked so that the district nurse, the supervisor, and the special consultants may follow their progress. In each record there are a complete history of physical and mental growth and development, narrative reports of the doctor's conference findings and nurses' home visits, data on conferences with consultants regarding prevention and treatment of special problems, and information on care to be given in case of illness.

When these children have been carried through their first five years, there should be interesting data worth studying and evaluating.

A GUIDE TO THE SCHOOL NURSE

Possibilities for vocational training and placement of the crippled child are of vital concern to the school nurse. Page 620.

A coöperative plan with the local medical society for physical examination of certain high school students is discussed on page 628.

Factors in the school which affect the eye health of children are included in the outline of nursing functions on page 625.

School superintendents were invited to participate in some of the rural staff conferences described on page 604.

When should the care of the child's teeth begin, and why? Page 584.

The Bradford Frame---With Variations

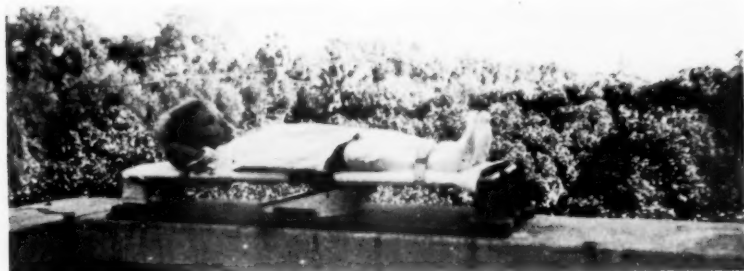


Figure 1

HAVE YOU ever wondered how the poliomyelitis patient confined to bed can twist and turn about so much when he has so little muscle power? I have—especially during our recent epidemic when at one time we had six new patients at the convalescent home, ranging in age from 16 months to 2 years. Not that the older patients didn't wiggle and squirm, too, but at least you could reason with them and cut down their activity to a certain extent. The frames illustrated here are especially for the younger group.

The orthopedic staff recommended the use of the Bradford frame. This brought the problem of how the children were to be placed on the bedpan. Slipping the bedpan under the child necessitated the removal of all the binders and straps used to keep him on the frame, and more serious, it meant the stretching of weak muscles which should be at rest, in many instances causing a good deal of pain as well.

The first step in the solution of this problem was as follows: The frame was raised several inches off the bed and the canvas frame-cover was made in two pieces, measured so that the opening would be under the buttocks. This plan worked well until one of the youngsters discovered that he could reach for the pan and to make a real adventure of it, send it flying across the room. Imme-

diately the other children in the room had to try the trick and an exciting time was had by all.

It was at this point that we decided to nail everything down! The frame was placed on standards $4\frac{1}{2}$ " high, made of 1" x 4" lumber, and was fitted securely into rounded notches in the center top of each of the standards. The standards were nailed to a piece of plywood 3 inches longer and 3 inches wider than the frame itself, making a firm base for the frame. Two 1" x 5" strips of wood were then nailed to the plywood far enough apart so that a bedpan could be inserted between them. The other measurements are, of course, determined by the size of the individual child. We have used this type of frame for our older children, too, with good success. (See Figs. 1, 2, 3.)

The frame with the hip abduction position (Fig. 4) was made by one of the fathers with a piece of 1" x 15" board. The measurements were taken by placing the child on the board and marking it for the bedpan opening. Five-inch slits were made in the wood at either side of the body, and the abdominal binder was put through these slits. At the lower end of the frame a three-cornered piece, measuring 10 inches from the edge of the board to the tip of the triangle, was cut to keep the hips in abduction. The limbs were held



Figure 2

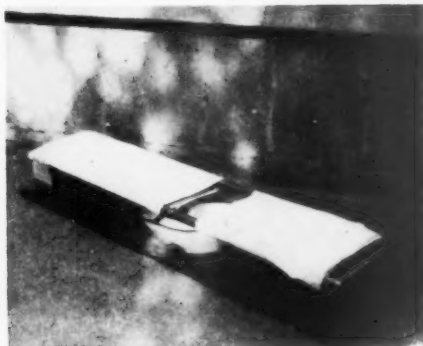


Figure 3

in place by slipping the webbing through two-inch slits in the wood made on either side of the ankle and thigh. Three pieces of wood were used in making the props for the feet, and the frame was then placed on two narrow wooden blocks in order to lift it off the bed. Soft padding was used to relieve the hardness of the board. This type of frame has been in use in many of the homes since its cost consists only of the price of the lumber, and in some cases, the one dollar which the wood turner charges to cut the holes—making a total cost of \$1.25.

The other wooden frame which was also found satisfactory was made in the

same fashion as the one last described. (See Fig. 5.) The lumber used in making this was a piece of 1" x 12". It also was placed on blocks. Since it is easy to carry from one room to another, it has proved especially valuable in homes where the problem of keeping the child in good position while letting him be with the rest of the family is so important.

We believe that these frames do much toward keeping the child "straight" and happy, which is half the battle in care of infantile paralysis.

MARIE L. CZWALINSKI, R.N.

Physiotherapist, Crippled Children's Division, State Department of Social Security and Welfare, Phoenix, Arizona



Figure 4

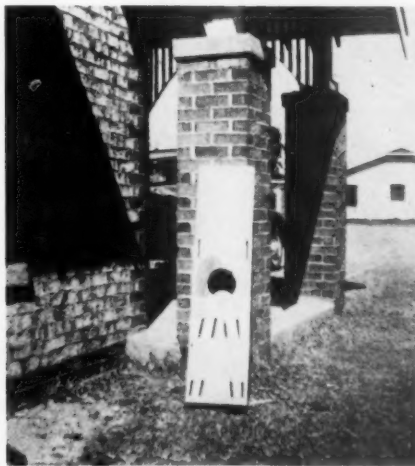


Figure 5

Staff Conferences in a Rural Health Unit

By M. GRACE WATSON, R.N.

A rural health department works out an in-service staff-education program based on the interests and needs of the members of the group

A STIMULATING program of staff education has been developed by the health department personnel to meet their own needs in the bi-county unit of Thurston and Mason in the State of Washington. The program was developed on the premise that public health personnel, like teachers in the school, need continuous opportunities for in-service education.

Schools throughout the United States endeavor to inaugurate some plan for improvement of teachers in service. Within the school, teacher improvement is encouraged by teacher meetings for the study of constructive and practical policies, the study of program and curricula, and the review and criticism of new textbooks. Besides teacher meetings, various other methods of in-service education are used, such as participating in approved educational projects, writing educational articles, and showing evidence of completion of professional reading. During the summer months, teachers are encouraged to combine travel and study. They are permitted to take a semester off for refresher courses. Sabbatical leave is a frequent method of teacher improvement.¹

All of these possibilities should not seem too remote to the public health personnel of a wide-awake health district. Public health workers are health teachers. Therefore it seems that staff education in service should be organized upon a sound educational basis. Since learning takes place best when new information can be related to the present situa-

tion, it is important that the staff plan their own educational program.

The plan to be described here has been carried out in a district which comprises the counties of Thurston and Mason on the shore line of Puget Sound. Together they have an estimated population of 45,000 and an area of 1679 square miles. Included in the unit is the city of Olympia, the capital of the state, with a population of 12,550,* and the city of Shelton with a population of 3091.**

The staff includes a health officer, a supervisory nurse, five public health nurses, a general sanitarian, a milk inspector, and a vital statistics clerk. All personnel meet the qualifications recommended by their respective professional groups for the positions they hold. The public health nurse of the Indian Service, who is the only other public health nurse working in these two counties, is invited to participate in the staff conferences.

The district is used by the University of Washington for rural field service for public health nursing students. One or two students have their field work here each quarter.

At a staff meeting in 1938 it was decided that the purposes of staff conferences should be:

- Staff education
- Planning of the general program
- Interpretation of policies
- Discussion of problems

*Figures for 1939 from State Department of Health.

**Taken from 1930 U. S. Census.

Suggestions for improvement in service

Since public health nurses are in the majority and nursing problems seem more numerous, it was decided that the nursing group would meet alone at each alternate conference, which would be devoted to nursing subjects. Topics of a more general nature would be discussed at the general staff meetings of all personnel. The general meetings are planned by the health officer or one of the sanitarians, and the coöperative relationships of the different types of workers are emphasized. The supervisory nurse was chosen to function as general chairman of all meetings but each conference is planned and conducted by an individual staff member. The health officer usually acts as one of the audience rather than the speaker and participates in the discussion.

WHEN AND WHERE?

Careful choosing of time is important to a successful conference. Friday afternoon at 3:00 o'clock is the preferable time in the unit for the following reasons:

1. School health work is at a minimum.
2. The health officer and supervising nurse are available for individual conferences following the staff meeting.
3. The sanitarians can best arrange to be present at this time.

Saturday morning was decided against because the personnel need this time to review the activities of the past week and to organize the following week's program.

One hour is considered sufficient time for a well planned conference. Ten minutes are allowed for a report on a current professional article. This responsibility is rotated alphabetically among the staff. Twenty minutes are ample for presentation of the subject chosen for the meeting. Group discussion and announcements follow. Frequently, however, an interesting discussion does carry the meeting over the allotted hour. This is

another factor in favor of the time that was chosen.

The place of meeting does not necessarily need to be the health department. In fact, there are certain values in a mobile staff conference which is held in different parts of the area.² By varying the place in which the staff meeting is held and by inviting prominent individuals of the community to participate, it is possible to acquaint citizen groups with the objectives and problems of the department. Almost every district has one or more outstanding individuals engaged in some phase of health promotion, who are interested and willing to participate in the program. Another important factor of mobile staff conferences is that it helps the outlying districts to realize that they have a complete health department serving their area and that the public health nurse is the department's representative in their community.

WHAT DOES THE GROUP WANT?

The first step in planning any sound educational program is to ascertain the interests and needs of the staff. It has been suggested that: "The simplest way to determine the interests of the group is to ask each individual to voice his needs. This method, however, is successful only when the staff has had enough experience to recognize and analyze its problems and has the courage and ability to express them."³ The truth of this principle is apparent in comparing the programs as they were planned and carried out in 1938-1939 and in 1939-1940.

During the first year the staff was not entirely sure what it needed most. There was evidence of widely varied interests, but each staff member showed initiative in planning the details of conferences with real educational value in mind. Different types of conferences were used: round-table discussions, symposia, field trips, and lectures. Staff members be-

came accustomed to expressing themselves in the group and developed a sense of responsibility for the success of the conference through active participation.

When the same staff met in September 1939 to make plans for the winter, the members had much more definite ideas as to what they wanted. The nurses were unanimous in the desire for a study of the maternal and child health program. The staff felt the need of a better understanding of the United States Public Health Service Milk Ordinance. Since rabies was threatening to become epidemic among dogs, it was important that all personnel be advised regarding measures for control and treatment. The sanitarian chose to acquaint the other personnel with the sanitation of Olympia industries.

A brief outline of the programs for the two years follows:

STAFF CONFERENCES, 1938-1939

Round-table discussions

1. Health in the school.

This meeting was conducted as a round table and school superintendents were invited to attend. The need for the school nurse to understand the child's family background, problems, and resources was brought out, and the superintendents saw the value of a generalized service with nurses doing complete family health work.

2. Relationship of the orthopedic program to the health department.

The orthopedic consultant of the State Department of Health explained the details of orthopedic referrals and follow-up in the present program.

3. Relationship of welfare medical service to the health department.

The local welfare administrator and the medical social worker attended this meeting. Avenues were established for referrals which clarified the problems of patients entitled to medical relief.

4. Lay participation in the public health program.

Members of the local coordinating council attended this meeting, at which the proposed advisory and public health council was discussed.

5. Coöperating agencies.

A representative from the tuberculosis asso-

ciation outlined its program for the year. The coördination of its work with that of the health department was discussed, particularly with a view to avoiding duplication in nursing service.

6. Traffic safety council.

This meeting was conducted with the participation of the safety council educational chairman and the engineering and enforcement officer.

Symposia

1. Methods of educating the public.

A symposium on public education was conducted by a commercial artist, a newspaper reporter, and a radio broadcaster. The application of methods in their specialized fields to the health education program of the community was discussed by the public health nurses.

2. Maternal care.

Maternal care was presented from three angles: a mother's viewpoint was given by a woman's club representative; the medical aspects were discussed by a local physician; the function of the public health nurse was outlined by a member of the local staff.

Field trips

1. Water supply.

The sanitarian conducted a field trip to the city water supply where the plant superintendent gave a very informative talk on the control of public as well as private water supplies.

2. Sewage disposal.

A well informed private physician talked on the best methods of waste disposal in a seaport city the size of Olympia. He also pointed out the shortcomings of the present system.

3. Dairy inspection.

A field trip was made to various types of dairies, where the milk inspector pointed out the merits and faults of each type.

4. Port of Olympia.

A United States customs officer gave a talk, "The Ship's Bill of Health," on maritime sanitation and quarantine regulations.

5. Sanitation in the Civilian Conservation Corps.

The company commander in charge of a camp took the staff on a tour of inspection, showing various aspects of group sanitation, including the storage and preparation of food, the sleeping quarters, and bathing and toilet facilities.

Lectures

1. Mental hygiene.

The psychologist of the State Department of Social Security was invited to speak. This discussion resulted in the opening of a new

service. Patients found by the public health nurse were examined by the doctor, and on his recommendation, by the state psychologist. From these findings of nurse, physician, and psychologist, recommendations were made and treatment instituted.

2. Legislation.

This meeting was conducted by a state legislator to acquaint the staff with the laws pertaining to public health which had already been passed and those which were before the legislature.

STAFF CONFERENCES 1939-1940

General staff meetings

The general staff meetings during the past year were devoted to a study of dairies and the United States Public Health Service Milk Ordinance, the treatment and control of rabies, and the vital statistics of the district.

Field trips

Field trips were made to several industries.

Nurses' meetings

1. Home visits.

The nurses planned a series of eight home visit dialogues between a normal antepartum patient and the public health nurse. Each dialogue was prepared and typed before the meeting, and a copy placed on file where it could be read by the staff. Discussion and criticism by the nurses not participating in the dialogue were encouraged. Each dialogue was accompanied by a demonstration, such as the preparation of a tray for breast care, or the

making of an abdominal binder. The bag technique was revised and this was demonstrated at each meeting under the scrutiny of the other nurses.

2. Maternal and infant nutrition.

Six staff conferences were conducted by the state nutrition consultant as a refresher course in which the fundamentals of nutrition were reviewed.

3. Eye health.

A splendid two-day institute on eye health was held by Eleanor W. Mumford, associate for nursing activities of the National Society for the Prevention of Blindness.

4. Orthopedics.

A study is being made of orthopedic conditions and treatment. An outline prepared by the nurse consultant in the State Department of Health is used for review. The consultant will conduct the last two meetings, using a manikin for demonstration purposes.

This discussion of staff education in service tells the story of how staff conferences have been planned and carried out in a rural health department with a comparatively small staff. The cost of these conferences in miles of travel and hours of personnel time may be estimated in dollars and cents, but the value to the community in terms of improvement in service is an immeasurable—though visible—result.

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Measuring the Quality of Our Work

An experiment in qualitative evaluation: A method of reviewing case records to improve the quality of nursing service

A REVIEW of current literature, reports, and recent requests to the National Organization for Public Health Nursing from executives indicates that all progressive agencies administering public health nursing services are concerned about ways of measuring the quality of service. Quantitative measurements have long been utilized. The great need now is for objective material upon which observations in regard to quality can be based. With that need in mind the Committee on Nursing Administration of the N.O.P.H.N. undertook an experiment in qualitative evaluation to determine what objective data might be helpful in such analysis and also to determine the method which might prove helpful. It was agreed that the procedure had to be simple since few agencies have skilled statisticians or analysts at hand. Obviously, if improvement were to be measured, the method must lend itself to periodic review of similar data. This report is the result of that experiment.

TUBERCULOSIS RECORDS CHOSEN

The case record was selected as the logical source of information from which data could be secured regarding the case and the nurse's service to the patient and his family. In most public health nursing agencies the case records which are used contain sections for the recording of pertinent facts by checks and in columns, and also for the progressive narrative notations of the nurse. It was thought that both sections offered tangible material for review.

Tuberculosis supervision was chosen because the terminology and the criteria upon which good supervision is based

are more standardized than for some types of service, and therefore should vary less among agencies; and because patients and their families receive nursing supervision which lends itself to measurements of quality based upon evidences of the effect of services over a long period of time.

It was considered that intelligent nursing supervision was hardly possible if the nurse did not have as a guide data relating to the epidemiology, diagnosis, and follow-up of the case. Evidence of knowledge of the use of these data in supervision of the patient and family should be present on the case record or their absence should be explained; otherwise, continuity of care could not be assured. Since the aim of this report is primarily to suggest a method, only five of the factors essential to tuberculosis control were selected as possible qualitative measurements.

It was considered that every case record would be expected to contain (1) data relating to the examination of sputum, since such information is essential to the nurse in her effort to prevent the spread of infection (2) history of institutional care, since such care is recognized as valuable for the patient and the contacts and of paramount importance in the case of a patient with positive sputum (3) data regarding medical diagnosis, since this information shows the severity of the disease and also the progress of the patient (4) the number of days between the date of discharge from an institution and the date of the first subsequent home visit, since the shorter this period the more assurance there is of continuity of care from institution to home (5) the per-

cent and age of contacts examined, since the more complete the contact examination the greater is the opportunity to protect the family and the community from further illness.

It will be recognized that these five factors in tuberculosis supervision are not new. They have long been considered fundamental factors but are not inclusive of all the information which is important if the nursing service does its part in a planned tuberculosis service to the patient, his family, and the community.

SOURCE OF DATA USED

Five selected nursing agencies, official and nonofficial, consented to participate. They agreed to provide a random sample of family case records in which the index case was one of clinical tuberculosis. The families selected were to have been known to the nursing service for one year or longer.

METHOD OF MAKING STUDY

A schedule* was drafted to provide an outline for summarizing the data on the case records selected, particularly those pertaining to the five factors selected as indicated above. In addition, a blank sheet was used for each family record studied in order to note significant facts* recorded by the nurse, which were not specifically required on the record and possibly would not lend themselves to tabulation on any schedule. Notations were made of such items as gave evidence of the nurse's attempts to secure required information although the failure to record the item had of necessity been entered on the schedule as "not stated." Also, evidences of skillful or characteristic entries of the nurse were copied by the reviewer on the blank sheets, with the dates and initials of such entries.

*The completed schedules and notes for the D— and K— families are shown at the end of this article, to illustrate the schedule and coding used.

Notes showing unusual emphasis in the organization were copied, with dates. It is evident that a filled-out schedule plus the selected notes on the blank sheet would provide a supervisor with objective suggestions for encouragement and guidance in conferences with the staff nurses. The schedule was prepared and the data collected by the statistician for the N.O.P.H.N.**

The surveyor visited each agency and reviewed the family records with a supervisor, filling out with her the study schedule for one family and entering on the blank sheets significant notations. The length of time required for summarizing the record of a tuberculous family varied with the completeness of the record, the number of persons in the family, and the type of entries in the running notes section. If a fact called for on the schedules had not been entered on the record at any time by the nurse serving the family, an entry of "not stated" was written after that particular question on the schedule. No effort was made to secure additional information either from the field nurses or from other sources while the tuberculosis records were being summarized.

Each schedule was coded according to the categories and symbols shown in Tables I to IV, in order to translate the facts entered upon the schedules into classifications suitable for tabulation. Two schedules of families D— and K— are reproduced to indicate the method used. The large symbols in circles in the left-hand margin of the D— and K— schedules (see pages 616 and 617) indicate how the categories applied to the two families. Actually, in coding these schedules, colored pencils were used, so that codings for use in Table I were in red; Table II codings were in blue; Table III codings were in green; and Table IV codings were in brown. Using colored pencils is a helpful mechanism to make tabu-

**Dorothy E. Wiesner.

CONTACT CARD

A. 1. Family name . . *D----*

(C) 2. Stage of tbc. index case *Far advanced*

(A) 3. Sputum data *Two positive sputum reports*

B. 1. Contact's name . . *Anna*

(C) 2. Age *51 years*

3. Examined or not examined . *Yes*

NOTE: The first circled C is in blue; the second in brown; the circled A is in red

lating and checking easier. Each schedule was coded in this way. The records of 86 families were included in this study.

CONTACT INFORMATION COPIED

Information regarding contacts was transferred to 3" x 5" cards, one card for each contact, similar to the above.

The age of each contact was coded on the contact card according to the letters used in Table V on page 613. The codings appear in the circles on the left-hand margin of each card. Completeness of contact examination work could thus be tabulated more readily in relation to the ages of the contacts, and to the stage of tuberculosis and sputum data of the index cases. The time spent in copying was more than saved in the tabulating. It is far easier to sort 388 contact cards into piles, each one coded so that there can be no question of its classification, than to use the stroke method for even slightly complex tables.

TABULATION OF FAMILY SCHEDULES

The 86 schedules, one for each tuberculous family, were arranged according to the codings written on them about sputum data. The number coded "A"

were counted; the number coded "B" were counted, et cetera. Table I shows the findings according to the sputum data about the index cases.

TABLE I
SPUTUM DATA ABOUT INDEX CASES OF
TUBERCULOSIS IN THE NURSING RECORD

Cases by sputum data in the nursing record	Number of cases
Total index cases	86
A. More than one positive sputum examination noted	25
B. Only one positive sputum exam- ination noted	22
C. No positive sputum examination noted but more than one neg- ative examination noted	12
D. Only one negative sputum exam- ination noted and no positive examination	3
E. No notation about sputum exam- ination	24

While the 86 schedules were still arranged in the five piles from which Table I was made, it would have been possible to cross-classify them to show how many of those marked E, "no notation about sputum examination," had far advanced tuberculosis. No cross tabulations were attempted in this study, however, since 86 is too small a number

to break down minutely. One is open to criticism for presenting percentages based on only eighty-six families. Certainly none of the findings presented here should be considered as standards. Therefore, percentages do not appear in Tables I to IV. The observations made in relation to each tabulation are suggestive of their use and are not to be considered as a critical analysis of the nursing work done on the cases studied.

The figures in Table I are obtained from the answer to question 6 in the Family Tuberculosis Summary (see page 616). There were 25 summaries coded "A" in red, meaning that on the nurse's record there were two or more dates of positive sputum examinations. There were 22 of the summaries coded "B" in red, meaning that these 22 family records had only one date of a positive sputum examination, either with or without other dates of negative sputum. The categories in Table I are mutually exclusive, a necessary arrangement if tabulations are to add up to the total number.

It is significant that 24 patients out of 86 had had no sputum examination made—or if such an examination had been made, the data did not appear on the nursing record. In other words, in a considerable proportion of cases the nurse was without one of the most important items of information in regard to the condition of the patient and the danger of transmitting the disease to others.

STAGE OF TUBERCULOSIS

The stage of tuberculosis of the index case is given in question 5 in the Family Tuberculosis Summary. These answers were coded in blue to the left of question 5. On the D—and K—schedules, both index cases were in the far advanced stages of the disease and are therefore coded "C" to agree with the "C" in Table II. This table shows that only 19 of the 86 index cases were stated

to have minimal tuberculosis according to the nurses' records. For 14 of the tuberculous patients—coded "D"—the stage of the disease was never entered, which means that the nurse did not have a definite diagnosis showing the severity of the disease and the patient's progress—information which would seem to be basic to any intelligent plan for the patient or family.

TABLE II

STAGE OF TUBERCULOSIS OF THE INDEX CASE AS FIRST STATED IN THE NURSING RECORD

Stage of tuberculosis of the index case as first stated in the nursing record	Number of cases
Total index cases	86
A. Minimal	19
B. Advanced	29
C. Far advanced	23
D. Stage not stated	14
E. Miliary tuberculosis	1

There was no definite proof found in this study that one nurse more than another was able to secure the facts about the tuberculous families. In the upper right hand corner of each Family Tuberculosis Summary is a section for the names of the nurses who signed the record of the visit. In no instance did the reviewer find one nurse carrying the family for the entire period. Vacations intervened and families moved. Not until this method of reviewing records has been tried out in a larger way can one be sure that nurses in the same agency vary in securing factual data of this kind. It was found to be of value, however, to copy the notes of a nurse who explained that she had tried to secure precise data even if she failed. Enough entries of unsuccessful trials point to a next step. It is believed that the use of the blank sheets in addition to the Family Tuberculosis Summary is of definite value in this connection.

PROVISION OF INSTITUTIONAL CARE

The provision of institutional care depends upon the recommendations of the physician and in great part on the number of beds available. It would seem that a public health nurse caring for a family in which there was a patient with positive sputum tuberculosis would have as part of her plan the protection of the family, particularly children, from infection through removal of the patient to a hospital or an alternative plan. If she could not accomplish this it would seem that her notes should contain an explanation of why her efforts failed. Such entries were, however, infrequent in the records studied.

TABLE III
TIME BETWEEN DATE OF REFERRAL TO
NURSING SERVICE AND DATE OF FIRST
INSTITUTIONAL CARE

Time between date of referral to nursing service and date of first institutional care	Number of cases
Total cases	86
A. Within two weeks	12
B. 14 to 29 days	14
C. 30 to 59 days	12
D. 60 days and more	10
E. No institutional care	18
F. Referred to nursing service after admission to institution	20

One surprising finding among the 86 family records which were summarized is that 20 of the patients were referred to the public health nurse *after* the index case had been admitted for institutional care. These records are all fairly recent. Institutional care data for Table III were obtained from questions 7 and 8 on the Family Tuberculosis Summary. Line E shows that 18 did not go to a hospital for institutional care. Some of these were patients who had received collapse therapy, for whom there appeared to be no further need for institutional care. For some, however, no reason was recorded in the nurse's record to explain the lack of institutional care.

RETURN TO HOME FROM HOSPITAL

The number of days between discharge from the institution and the first subsequent home visit by the nurse offers one simple way of judging whether community machinery is working well. The opportunity for continuity of care is presumably increased if the lapse of time is short. If the number of days between the discharge from an institution and the first subsequent home visit by the public health nurse is more than a month, or even more than two weeks, high quality of work is not indicated. The length of time between the date of discharge from the institution and the date of the first subsequent home visit by the nurse is obtained from questions 7c, 9, and 10.

There were some few instances among the 86 families in which immediate home visiting was impossible because the patient was lost sight of, the family having moved. The date of discharge was considered and not the date on which the notice of the discharge was received in the public health nursing agency. The number of *days* between the two dates was counted, since tabulation is simpler if number of days is considered, rather than weeks or months.

TABLE IV
NUMBER OF DAYS BETWEEN DISCHARGE
FROM INSTITUTION AND FIRST SUBSE-
QUENT HOME VISIT BY NURSE

Number of days between discharge* from institution and first subse- quent home visit by nurse	Number of cases
Total cases	86
A. Less than 7 days	8
B. 7 to 13 days	17
C. 14 to 29 days	11
D. 30 days and more	10
E. Still in institution	15
F. Patient died in institution	6
G. No institutional care	18
H. Date of first subsequent visit not stated	1

*Actual date of discharge regardless of when notice was received by agency.

Table IV shows that 47 of the 86

patients (Lines A, B, C, D, and H) were discharged from institutions for the care of tuberculosis. Only 8 of these were visited in their homes by a public health nurse in less than seven days (See Line A). Ten of the 47 were not visited until thirty days or more had passed after discharge from the hospital. These findings may appear discouraging. After they were brought to the attention of the executives interested in the public health nursing program in two of the cities visited, the plans for reporting of discharges from the institutions were revised, so as to facilitate promptness of follow-up visits.

EXAMINATIONS OF CONTACTS

The importance of the public health nurse in securing physical examinations for the contacts of tuberculosis patients is well known. No service could be considered of good quality if this part of the program had not been accomplished,

following whatever plan for examination and re-examination the clinician or physician may prescribe. In the 86 families there were 388 household contacts to be examined. These are exclusive of the original 86 tuberculous patients, the index cases. Of the contacts, 161 were under 20 years of age; 108 aged 20 to 39 years; 94 aged 40 years and over. For 25 contacts, the ages were not stated.

Of the 388 contacts, 68.6 percent were examined. The many changing factors that can influence the securing of examinations of contacts must be considered in making comparisons in the same organization from year to year. The following tables show that one may expect more complete contact examination work among families with many young people. See line A of Table V, which shows that 87.6 percent of contacts under twenty years of age were examined.

TABLE V
EXAMINATION OF HOUSEHOLD CONTACTS ACCORDING TO AGE GROUPS

Age groups of household contacts	Total contacts to be examined	Number of contacts examined	Percent examined
Total	388	266	68.6
A. Under 20 years	161	141	87.6
B. 20-39 years	108	67	62.0
C. 40 years and over	94	49	52.1
D. Age not stated	25	9	36.0

Possibly families that have been under care for a long time might show more complete contact examination work, although studies have indicated that the early weeks after the diagnosis of the index case are the most fruitful days in which to secure contact examinations. Emphasis has been placed recently on the examination of persons in the 20- to 39-year group. Table V shows that only 62.0 percent of this group were examined, whereas 87.6 percent of those under twenty years of age were examined. Since more clinical tuberculosis is discovered among adults than among children, would it not be an indication

of improvement of quality of service if in studies of summaries made in a similar way five years hence, an appreciable increase was found in the percentage of examination of older contacts?

Contact examinations related to sputum data about index patient

The continuous exposure of a contact to a patient with positive sputum is a well recognized hazard which points to the necessity for greater supervision and more frequent examinations of contacts so exposed. From Table VI it will be noted that when contact examinations are tabulated according to sputum re-

TABLE VI
EXAMINATION OF HOUSEHOLD CONTACTS ACCORDING TO SPUTUM DATA ABOUT THE INDEX CASE IN THE FAMILIES

Contacts by sputum data about the index case in the family	Total contacts to be examined	Number of contacts who were examined	Percent examined
Total contacts	388	266	68.6
A. Index case—More than one positive sputum examination noted	123	86	69.9
B. Index case—Only one positive sputum examination noted	108	79	73.1
C. Index case—No positive sputum examination but more than one negative sputum examination noted	45	30	66.7
D. Index case—Only one negative sputum examination and no positive	15	9	60.0
E. Index case—No data about sputum examination	97	62	63.9

ports about the index case there was surprisingly little variation shown. One would expect that the percentage of examinations would be by far the highest in line A, "index case—more than one positive sputum examination noted," since the danger of infection would be best recognized in these instances. Yet there is little difference between the percentage of contacts examined in this group and in the group with no positive sputum examination.

Contact examinations related to stage of tuberculosis of the index case

The relation of contact examinations to the stage of tuberculosis in the index case is also significant. Surprisingly, line E, "stage not stated," in Table VII, shows the most satisfactory percent of contacts examined. There were 58 con-

tacts in this group, and 49 of them, 84.5 percent, were examined; one would think that these contacts had been living in families in which the index case was in a highly infectious state. But only sixty percent of those in contact with minimal tuberculosis were examined. Sixty-six percent of those in contact with advanced tuberculosis were examined, and only 69 percent of those in contact with far advanced tuberculosis were examined.

In each of the cities represented by the 86 schedules, free clinic service, free x-ray service, and free institutional care were available. The waiting list for institutional care varied among the five cities, however. These variations serve to emphasize the previous statement that all related factors must be kept in mind in studying quality of tuberculosis service in the way outlined in this discussion.

TABLE VII
EXAMINATION OF HOUSEHOLD CONTACTS ACCORDING TO STAGES OF TUBERCULOSIS OF THE INDEX CASES IN THE FAMILIES

Stages of tuberculosis to which contacts were exposed	Total contacts to be examined	Number of contacts examined	Percent examined
Total contacts	388	266	68.6
A. Minimal	88	53	60.2
B. Advanced	129	85	65.9
C. Far advanced	110	76	69.1
D. Miliary	3	3	100.0
E. Stage not stated	58	49	84.5

INCIDENTAL FINDINGS

Even though this analysis was not designed to provide a critical study of the service rendered by each nurse or by the agency, certain observations of the records made by the reviewer led to immediate inquiry as to cause. Seeing certain facts in tabular form provides a picture striking enough to point to a problem otherwise not recognized.

In one instance it was discovered that while the sanatorium had been sending a list of discharged patients to the nursing organization, the names were allowed to accumulate for as long as a month. In another it was found that established methods for letting the agency know about sputum tests at the city laboratories were not working well.

The value of such entries as "Complete tuberculosis visit" or "Advised all precautions" as the narrative account of the home visit, with the date and name of the nurse, was discussed with the supervisor. Such entries seem time-saving at the moment but they are not so valuable for a longer view. A better entry was: "Explained reasons for and methods of tuberculosis precautions and isolation in view of recent findings. Patient not deeply impressed with the idea of isolation."

In some records it was evident that the nurse on her first visit to the household found that the patient was not aware his physician had diagnosed and reported his illness as tuberculosis. Such findings in the records were sometimes a surprise to the director of the agency. Entries about other social agencies varied widely, as did data about economic status. It was interesting to note that the word "uncoöperative" seems to be definitely ruled out. Only once was it noted in the entire study of 86 families.

Some organizations used red ink for all entries which did not describe the nurse's own observations. This is a helpful technique. Red ink was used for

reports from hospitals, laboratories, social agencies, et cetera. Present thinking about recording is that entering the day, month, and year of pertinent items of information is of the utmost importance. It is not enough to say, "In the spring of 1938 the youngest child lived with the grandmother." The exact day, month, and year in which the information is written on the record form are also of importance.

The Committee on Nursing Administration believes that the method of reviewing records described in this report is a practical one adaptable to any agency wishing to make a qualitative study of its service. It seems to the Committee that the time required for studying the 86 records used for this study, in entering the data on schedules, and in tabulating the data as here reported is a justifiable part of supervision and administration since it offers a tool to provide better service. This report is presented with the hope that it will stimulate more thought on this subject of qualitative evaluation and that further experimentation will result in better measurements. The Committee is continuing its work and already has under way a schedule to use in evaluating infant welfare and antepartum service.*

The Committee acknowledges with appreciation the help of the five agencies who participated in this study, the invaluable assistance of Dorothy E. Wiesner who did the bulk of the work, and the financial aid of the Committee on Administrative Practice of the American Public Health Association who secured a grant of money for this purpose.

MARION SHEAHAN, R.N.
*Chairman, Committee on
Nursing Administration*

*The schedules used and excerpts from the nurses' notes appear on pp. 616-618. The N.O.P.H.N. will be glad to assist any agency wishing to use this method of service evaluation.

Name of family S - - - - Nurses serving them, with dates
 Case number 12,928 S - Apr 29, 1937 D - July 1, 1938
 White or colored white K - Jan 31, 1938 S - Nov 10, 1938

A. DATA ABOUT FIRST TUBERCULOSIS PATIENT KNOWN TO NURSING SERVICE

1. Name Patrick 2. Relationship in family Husband
 3. Date of birth Mar 17, 1877 4. How referred to nursing service: (a) Source State/Can/
 (b) Date Apr 23, 1937
 (C) 5. (a) Date of first diagnosis as shown on nurse's records Dec 6, 1936 (b) Stage of tubercu-
 losis as first stated on nurse's record Fair advanced
 (A) 6. Sputum examination data: (a) date of first positive sputum finding as shown on nursing
 record Feb 3, 1937 (b) subsequent dates of positive sputum
 findings Apr 30, 1937
 (c) Total number of reports of positive sputum 2
 (d) Total number of reports of negative sputum 2
 7. Institutional care: (a) where City Hospital (b) date of admission May 11, 1937
 (c) Date of discharge May 13, 1937
 (d) Reason for discharge Died at hospital
 (If more than one period of institutional care, use reverse side)
 (e) If no institutional care, state reason
 (B) 8. Days between date of reference to nursing service and date of first institutional
 care 19 days
 9. Date of first subsequent visit to home by nurse after discharge from institution
Patient died at hospital
 (F) 10. Days between return from institution and subsequent visit by nurse as hospital
being died
 11. Type of medical supervision with dates of visits to physician as shown on
 nursing records: (a) private physician
 (b) Clinic physician Apr 30, 1937 - May 5, 1937
 (c) Other medical supervision (please explain)

1/ Clinic physician visited Mr. S. at home.

B. DATA ABOUT CONTACTS

1. Name of contact	2. Date of birth	3. Relation- ship to first tbc patient	4. Examination of contacts for tuberculosis			
			a. First exam. after opening record			b. Dates of subsequent entries of examinations (use reverse side if necessary)
			Date of first chest exam- ination	Date of rotation of x-ray examina- tion	Diag- nosis Where exam- ined	
<u>Anna</u>	<u>1887</u>	<u>wife</u>	<u>June 21, 1937</u>	<u>June 26, 1937</u>	<u>normal chest cl.</u>	<u>none</u>
<u>James</u>	<u>1928</u>	<u>son</u>	<u>June 21, 1937</u>	<u>Apr 5, 1938</u>	<u>Primary chest cl.</u>	<u>Nov 28, 1937</u> <u>2/</u>
<u>George</u>	<u>1927</u>	<u>son</u>	<u>June 21, 1937</u>	<u>June 26, 1937</u>	<u>normal chest cl.</u>	<u>June 28, 1937</u> <u>2/</u>

2/ Visits continued on reverse.

Date of this summary Dec. 10, 1938

Person summarizing A. B. C.

Family Tuberculosis Summary N.O.P.H.N. 1939

NOTE: The circled C is in blue crayon; the circled A in red crayon; the circled B in green crayon; and the circled F in brown crayon.

Name of family K---- Nurses serving them, with dates
 Case number D 22 803 B- April 27, 1937 P- Aug 5, 1937
 White or colored white C- July 10, 1937 F- Dec 4, 1937

A. DATA ABOUT FIRST TUBERCULOSIS PATIENT KNOWN TO NURSING SERVICE

1. Name Thelma 2. Relationship in family wife
3. Date of birth Jan. 10, 1903 4. How referred to nursing service: (a) Source San
 (b) Date April 27, 1937
5. (a) Date of first diagnosis as shown on nurse's records April 27, 1937 (b) Stage of tubercu-
 losis as first stated on nurse's record far advanced
6. Sputum examination data: (a) date of first positive sputum finding as shown on nursing
 record none (b) subsequent dates of positive sputum
 findings none
 (c) Total number of reports of positive sputum none
 (d) Total number of reports of negative sputum none
7. Institutional care: (a) where State San. (b) date of admission April 17, 1937
 (c) Date of discharge Oct 23, 1938
 (d) Reason for discharge no reason stated
 (If more than one period of institutional care, use reverse side)
 (e) If no institutional care, state reason
8. Days between date of reference to nursing service and date of first institutional
 care referred to nursing service by sanatorium.
9. Date of first subsequent visit to home by nurse after discharge from institution
Nov. 5, 1938
10. Days between return from institution and subsequent visit by nurse 13 days
11. Type of medical supervision with dates of visits to physician as shown on
 nursing records: (a) private physician
 (b) Clinic physician none
 (c) Other medical supervision (please explain) In hospital, Oct 5, 1938
for pneumothorax treatment

B. DATA ABOUT CONTACTS

1. Name of contact	2. Date of birth	3. Relation- ship to first tbc patient	4. Examination of contacts for tuberculosis				
			a. First exam. after opening record				b. Dates of subsequent entries of examinations (use reverse side if necessary)
			Date of first chest exam- ination	Date of notation of x-ray examina- tion	Diag- nosis	Where exam- ined	
<u>Charles</u>	<u>n.s.</u>	<u>husband</u>	<u>none at</u>	<u>n.s.</u>	<u>n.s.</u>	<u>n.s.</u>	
<u>William</u>	<u>1926</u>	<u>son</u>	<u>none at</u>	<u>n.s.</u>	<u>n.s.</u>	<u>n.s.</u>	
<u>Mary</u>	<u>1927</u>	<u>daughter</u>	<u>May 10, 1937</u>	<u>n.s.</u>	<u>min. etc</u>	<u>city cl.</u>	<u>none</u>
<u>Ann</u>	<u>1930</u>	<u>daughter</u>	<u>May 10, 1937</u>	<u>n.s.</u>	<u>childhood</u>	<u>city cl.</u>	<u>none</u>
<u>James</u>	<u>1931</u>	<u>son</u>	<u>May 10, 1937</u>	<u>n.s.</u>	<u>neg.</u>	<u>city cl.</u>	<u>none</u>
<u>Thomas</u>	<u>1938</u>	<u>son</u>	<u>May 10, 1937</u>	<u>n.s.</u>	<u>neg.</u>	<u>city cl.</u>	<u>none</u>

Date of this summary

Person summarizing

Family Tuberculosis Summary
 N.O.P.H.N. 1939

NOTE: The circled C is in blue crayon; the circled E in red crayon; the circled F in green crayon;
 and the circled B in brown crayon.

FROM THE NARRATIVE NOTES

Excerpts from nurse's narrative notes for D—— family:

April 22, 1937. Mr. D—— says the Catholic Charities has promised their help since he has been advised to go to the state san. for treatment. (The record contains no follow-up of this.)

May 3, 1937. Bedside care started.

August 24, 1937. Children are at present in —— preventorium. Immediate home visit does not seem necessary. They were admitted July 6, 1937.

Condensed information about the D—— family taken from the record by the surveyor:

"Poverty" is circled as the economic status. Mrs. D—— was trying to support the children by doing housework and chambermaid work. Four persons live in a three-room apartment. The Family Welfare Society had registered the case in 1937.

The nurse took sputum supplies to the patient in April and explained the use of them.

Excerpts from nurse's narrative notes for K—— family:

August 3, 1937. Supervisor telephoned factory where father has begun work.

August 26, 1937. Cleaning instructions left. Examination of contacts urged.

March 21, 1938. Little sister reports brother's condition is good.

September 15, 1938. Neighbor downstairs states children do not get proper food and that they seem neglected.

October 4, 1938. All child contacts were examined. (No date of examination and no information about this appears for William.)

Condensed information about the K—— family taken from the record by the surveyor:

No social service exchange data. The printed entry on record, "Referred for relief," has "no" written after it.

Entries in running notes are not always visits, but include notes about the patient from other sources. It is impossible to tell which are visits and which are notes.

Although no sputum data are given on the nursing records, "care of dishes urged" appears November 5, 1938.

Record does not give data about clinic appointments, nor record of clinic attendance.

Each visit seems to be entered separately on each person's record rather than a record written for the family.

News From the S.O.P.H.N.'s

"PLEASE give us some ideas for our state meeting." Beginning in the spring this request is frequently received from state organizations for public health nursing. Some suggestions are offered here from our own experience with biennial conventions and from the experience of state groups:

PLANNING THE PROGRAM

It is recommended:

1. That at least some of the discussions be built around the particular needs of the nurses in the state.

2. That some time be given to questions of broader scope, such as national health programs or social and health issues of the day.

3. That time be allowed in small group meetings for discussion from the floor, under the leadership of someone who is skillful in guiding the discussion and pulling it together.

4. That overcrowded programs be avoided. One or two main speakers for a large general meeting are sufficient. Few speakers can cover a subject in less than twenty to thirty minutes; almost none can hold an audience over forty-five minutes. Some speakers will always run over their time. It is wise to allow a margin of ten or fifteen minutes for each talk in addition to the time allotted the speaker. It is better to close early than late.

5. That speakers be informed of the content of the entire program well in

advance, so that they can fit their contribution into the whole.

6. That persons who are to discuss other speakers' papers receive them in advance—a week if possible.

7. That reading of business reports, particularly statistical reports, be reduced to a minimum. The distribution of mimeographed copies of the report at the beginning of the meeting, rather than having it read, will save time. The members can then be given an opportunity to raise questions in the meeting.

THE MEETING

Physical conditions of the meeting have much to do with its success. A hot, close room has ruined many a meeting. (See "Give Us Air!" February 1940 issue, p. 74.) It is suggested that a monitor be responsible at each meeting for watching the temperature to see that it remains around 70° F, opening the windows for short periods at intervals to ensure circulation of air, and helping those sensitive to drafts to find seats away from the windows. Raising the windows while the audience stands up for a few minutes between speeches is an excellent plan.

GUEST SPEAKERS

It is suggested:

1. That guest speakers be sent a written verification of the place and time of meeting, with instructions on how to get there, if necessary.

2. That someone be delegated to meet the speaker at the door and usher him to the place where he is to sit.

3. That speakers arriving from a distance be shown a place to tidy up before the meeting.

4. That time be arranged for individual conferences of nurses or lay people with state or national visitors if their schedule permits, and that information be posted as to the place and time when visitors will be available for

individual conferences. (Nurses often hesitate to accost the speaker on the platform after the meeting and ask for an appointment.)

Hostess groups frequently ask how much entertainment they should provide for visitors, in order to show hospitality and still be considerate of their guests. Visiting speakers always like the opportunity to become acquainted with local groups. On the other hand they frequently have heavy field schedules with almost no opportunity for a breathing spell. They are grateful for hospitality which takes both these needs into consideration. A bit of time to collect their thoughts just before delivery of a speech is especially appreciated.

TIMELY TOPICS

Topics that might be discussed at state meetings include the following:

1. How is our state following up the recommendations of the White House Conference on Children in a Democracy?

2. What progress is being made in health insurance plans, group prepayment plans, and hourly appointment services?

3. What is our state doing about housing conditions in cities or in rural areas?

4. What progress is being made toward the development of community nursing service councils and bureaus?

5. What is the significance of recent studies—such as national surveys, statewide studies, or studies in cities—in relation to the state situation?

6. What is the status of rural home delivery nursing services in the state?

7. What is the status of industrial nursing in the state? (See page 631.)

8. What is being done to recruit students for schools of nursing and public health nursing, as a part of national security? (See *The American Journal of Nursing*, September 1940, page 1014. This might be a joint session with the state league of nursing education).

Vocational Training for the Crippled

By FREDERIC G. ELTON

The methods by which vocational training of the handicapped is adapted to the needs and potentialities of the individual are discussed by a specialist in this field

VOCATIONAL rehabilitation is an established governmental service directed toward the adjustment of the physically vocationally handicapped person in competitive employment. The presence of a physical disability does not in itself constitute a physical vocational handicap, and not all disabled people are in need of this service. The Bureau of Rehabilitation of the New York State Education Department is concerned with crippled young people who do have vocational handicaps. These handicapped persons are subdivided as follows:

1. Those who are employable in a suitable selected occupation (a) by the use of existing qualifications and abilities (b) by the acquisition of new knowledges and skills.

2. Those who are unemployable. These include persons homebound because of disability, those with emotional handicaps, those in need of further medical service, and those with other conditions which render them unacceptable in employment.

Those handicapped persons classified as employable are the group with which vocational rehabilitation is concerned. It is to these young people that the rehabilitation bureaus in the country offer guidance, training, and placement.

Vocational training is not an objective in itself. It is but a means to an end. That end, in general, is employment. Specifically, it is a particular job for a certain individual. Our thinking must therefore be in terms of employment needs and possibilities.

Frequently people who urge the vocational training of cripples fail to

realize that such training is only justifiable when employment possibilities and needs warrant it, and when the individual is mentally capable of profiting by it. Sympathetic and misguided thinking often considers training to be some magic art, applicable to all, which eliminates every difficulty that besets the crippled person. It is a part of this thinking that training in some mysterious way will accomplish all those things which public school education and medical and social science have failed to do. On the contrary, all persons coming in contact with these crippled young people should think in terms of employability. We are facing the hard realities of employment conditions and demands. The first step is to determine the applicant's potentialities for employment. In doing this we have three factors to consider—the degree of physical restriction, the mental possibilities and limitations, and the personality traits.

The individual's previous education, medical attention, and personality development are the factors fundamentally responsible for his degree of fitness for employment. Despite the presumption that maximum accomplishment has been achieved in education and physical restoration, we often find severe limitations in both.

ACADEMIC EDUCATION

General education, even with its present inadequate attention to social, industrial, and economic relationships, is unquestionably of tremendous im-

portance in bringing the young crippled person to a point where he has greater possibilities for acquiring a knowledge and skill which will enable him to compete successfully for a job. It is recommended that all crippled children, if mentally qualified, be urged to complete their high-school education, and that financial means be provided when necessary to make this possible. However, we are absolutely opposed to the practice, sometimes prevalent in public schools, of permitting these crippled children to be the recipients of special consideration, for whom scholastic standards are lowered. This is deadly to their future hopes and possibilities. The physically disabled child should be *better* prepared mentally than others in order to offset the limitations of disability and the prejudice of employers.

The advantage of high-school education is indicated by a study made by the writer of 70 crippled young people who were placed on their first jobs about three years ago and who were still employed when a study was made one or two years later. Forty-four had had one year or more of high school and 26 had left school at various grades in the elementary school. This group included only those children who had had no previous employment. All of them had received some kind of vocational training. For the high-school students the average initial wage on their first job was \$16.33 a week, while for the elementary school student, the wage was \$14.34. In the initial wage there was a difference of \$2, to the advantage of the high-school student. At the time of review, from one to two years following the establishment of this initial wage, the average wage of the high-school student had risen to \$18.57 a week, an increase of \$2.24, while that of the elementary school student was \$14.57, or an increase of only \$.23. The difference in weekly average between the high-school student and the elementary

school student is now \$4. The high-school student not only started with an advantage of \$2 a week, but at the end of one year to two years doubled his lead.

Employment is demanding, more and more, a greater background of education. These young people, if they hope to compete in life, must be prepared to meet these demands.

Something more, however, is needed. Attention must be given to preventing the development of a crippled attitude. Confidence and ability to think normally must be engendered. The development of a constructive social and work attitude is essential.

MAXIMUM PHYSICAL RESTORATION

Our experience in the field of physical restoration has taught us to question the impossibility of further physical improvement. When we have doubts on this point we turn to the most skilled surgeons for opinions. This desire to have the physically disabled child as nearly susceptible of employment as possible has led to the reduction of many disabilities and to the satisfactory adjustment of many a crippled child who would have otherwise stumbled along his path under great disadvantage. Earlier attention to this possibility of further correction of handicaps by all those in contact with the crippled child is important.

When every consideration has been given to raising susceptibility educationally, emotionally, and physically, and the maximum possibilities have been attained, we must analyze the degree of mental equipment, the degree of personality fitness, and the percentage of disablement in terms of possible employment. This analysis determines not only employability but the degree of vocational handicap, mentally and physically, and the consequent need for and possibility of assistance.

Applicants to be selected for voca-

tional training must be interested in training, in need of such assistance, and capable of profiting by it. The selection of jobs for which these applicants are to be trained is of vital importance in affording maximum employment opportunity. The job must be in keeping with both mental and physical possibilities and limitations. In all of our experience, emotional adjustment is the major controlling factor in the vocational adjustment of the disabled. A crippled attitude of mind renders more unemployable the youth with a lame leg than the one with useless legs supported by crutches but motivated by a healthy mental outlook. Confidence, social understanding, and mental alertness widen the range of employment possibilities regardless of the severity of the disability.

SELECTION OF THE JOB

In the selection of the job the personality requirements of the job are as important as the necessary knowledge or skill and physical fitness of the applicant. Requirements and conditions surrounding the job are already set. The problem becomes one of matching personality traits with job conditions and environment, knowledge and skill with job requirements, and physical ability with the physical demands of the job. While a one-armed boy could be an accountant from the physical standpoint, there may be nothing in his personality which qualifies him for this work even if he might appear mentally capable of it.

STUDYING THE APPLICANT

With these things in mind we turn to the analysis of the applicant in order to obtain the data necessary for job selection. This analysis takes the form of interviews, which must be conducted with an unbiased mind. Interests should be uncovered and their soundness tested and estimated. The characteristics of

the person should be studied for certain abilities. The individual may then be given psychological tests, particularly to discover aptitudes. The results will tend either to support or contradict what has already been recorded. They should be considered in the light of all the information on hand. They are not infallible. The knowledge secured from the various organizations and people who have known the individual is important and interesting. Oftentimes it will be found contradictory. In all, a fundamental understanding of the reaction of young people to their environment, and of their hopes, ambitions, and indiscretions is necessary if we are to be just.

In order that all of this information may mean something, it is necessary that the counselor should have an understanding of the economic demands of business, and at least a general knowledge of the requirements of various jobs. The greater this knowledge the more successful will be the result. There is no place in this examination for assumption, bias, or the imposition of individual likes and dislikes on the part of the examiner.

LOOK TO THE FUTURE

In determining the occupation for which the young person should be fitted, and the training necessary to qualify him for it, it is well to consider those jobs in which the novice will be employed. It is folly to attempt to prepare the disabled young people for work which they can accomplish only after experience in industry or years of study. True, we should prepare them to advance in their chosen field, but they must start before they can advance. We should also look ahead to their mature life, considering the things that they must do as they become older if they intend to remain in employment. The goal is permanency of occupation rather than temporary adjustment. There are, of course, changes in mental reactions and physical

condition which cannot be foreseen, but insofar as possible sound judgment tempered with practical sympathy should be the rule.

The coöperation of employers at this point in the plan is of great value. It is good policy to interest an employer who is engaged in the work in which the job exists as a consultant on the fitness of the young person for the job under consideration. Such consultation with employers will not only secure valuable information but will bring home to them their responsibility. An advisory committee of employers, as a group, is useless. Individual employers as advisers are of great value.

Inasmuch as these young people have the capabilities and characteristics found in a cross section of the young people of the state, their latent occupational possibilities are as diversified as those in the cross section. The types of jobs for which they are prepared and in which they are employed are found to be as extensive in scope as the range of occupations in the state. This is illustrated by a survey which the writer made of 101 crippled young people, all of whom received training and were rehabilitated two and three years ago. These 101 individuals received 37 different kinds of training, commercial, trade, and professional, and have filled 48 different kinds of jobs in 74 different kinds of businesses.

Government has not only set up a program of guidance for these young people, but it has provided that this guidance shall continue throughout the training period and into employment. This is made possible in New York because the state finances the course of instruction and places the choice of training agency and the supervision directly in the hand of its Bureau of Rehabilitation. Here, then, we have an interesting setup. It is a system of vocational guidance in which the counselor is held responsible for making

effective the counsel he has given. His judgment and guidance ability are tested in the resulting realities and not in theory. When the counselor gives advice or formulates a plan, he becomes the pilot. He stays with the ship, and his becomes the task of doing all he can to prevent a crash and bring it to a happy landing.

SELECTION OF A TRAINING AGENCY

Inasmuch as the capabilities of these young people for jobs vary from fitness for the most unskilled, simple tasks to fitness for the highly skilled professions, it follows that the training required will be as varied and the opportunities for preparation must be equally broad. No one institution could possibly provide all of these opportunities. Consequently, the bureau seeks them throughout the state in every available school, both public and private, and in employment. Home-study courses are seldom used, except in conjunction with a definite resident course either in an institution or in employment. The number of people who can profit by home-study courses, lacking the guidance of a teacher, are very few. Both day classes and evening classes are used.

After selecting the kind of training, it often becomes necessary to select from among those agencies offering it, one which is particularly adapted to the needs of the individual. The dull boy or girl who requires elementary clerical knowledge will not receive in every commercial training agency the attention which is needed. Often location is a factor in selection, in order to avoid carfare. Again, location may be disregarded because of the greater advantage of a remote school for a certain individual. The real interest and ability of some schools in placing their students is a factor in selection. The inability to secure in an educational institution the type of training required may lead to an arrangement with the employer for

training on the job. Again, this may be the best type of preparation for some young people. The atmosphere of the shop may be more suitable than the atmosphere of the school. The selection of the training agency, as every other part of the process, is based on the needs of the individual.

THE RESULTS TO BE SOUGHT

The first and paramount goal is the right of each one of these crippled young people to be employed and self-supporting when possible. The unreasonable objections of industry and employers must not be considered a factor in the question of possibility. To help them secure this right, the rehabilitation service was established and cost ceases to be the primary factor any more than in our educational system throughout the country. The permanency of the results, however, does indicate the value of the service in aiding the young people to become self-supporting, and the return on the investment shows its economic value. In discussing the permanency of employment, it must be remembered that these young people are not only susceptible to those things that influence and operate against every young person, but they have the added obstacle of disability.

A study was made of the group of 101 crippled young people mentioned above, one to two years after rehabilitation. It was found that 70 were still employed, 16 were unemployed (practically none of whom were out of a job because of being unsatisfactory), 7 could not be located, 1 (a girl) had been married, 2 were sick, 1 had died, and 4 had been re-entered in training. Thus,

we find that employment stability* in the group is about 80 percent. This percentage is higher than the general percentage of employment stability in the state.

Economically, our investment in these crippled young people is sound. The average cost of rehabilitating one of them is \$500. The state has invested \$50,500 in the 101. Without including the wages which had been earned by the 31 not now employed, we find that the earnings for one year of the 70 now employed were \$57,512—or \$7012 over the investment. In other words, in productive value the 70 had returned in one year more than the total investment for the 101. This does not take into account the fact that at the time of review there had been an increase in wages for these 70 of \$4368.

Thus we find that these young people not only put back into the state in productive and purchasing power the whole investment of the state, but in the first year of employment this new productive and purchasing power represented 114 percent on the investment. The expenditure of this money on the part of the state is no gamble. Here is a service in which the returns on the cash investment can be measured in dollars as well as in human rights and happiness. It is a unique educational system based on individual differences and needs and promoting individual development, achievement, and happiness.

*Employment stability as used here refers to the percent of employable people in a given group who are working at a given time.

Presented before the class on orthopedic nursing, Teachers College, Columbia University, New York, New York, April 5, 1940.

Nursing Functions—Eye Health

The Nursing Advisory Committee* of the National Society for the Prevention of Blindness defines nursing functions which contribute to the promotion of eye health

THIS STATEMENT was prepared to show how the nurse in any phase of nursing may help to promote eye health. Public health nursing aspects as presented in this outline have been cleared with the National Organization for Public Health Nursing.

Protection and promotion of eye health are a function of nursing. Indirectly all nursing functions which contribute to general health also assist in maintaining the health of the eyes and in saving sight. The prevention of ophthalmological conditions, however, lies largely in recognition of the interrelation of eye health and general health and in the development of health, educational, industrial, and social programs which give adequate consideration to the maintenance of eye health. Nursing functions in such programs contribute both directly and indirectly to the health of eyes.¹

NURSING FUNCTIONS

The functions of the nurse in relation to eye health are outlined as follows:^{2,3}

1. To help analyze problems related to eye health and participate in formulating ade-

quate health programs with due regard to eye health.

2. To help develop and coordinate community services and programs for the protection and promotion of general and eye health, utilizing community resources to aid individuals.
3. To assist in adjustment of environmental conditions to favor the health, safety, and comfort of the eyes through:
 - a. Helping to eliminate hazards to the eyes.
 - b. Helping to secure adjustment of lighting and posture to meet individual needs for safe, comfortable, and efficient use of the eyes.
4. To assist in medical examinations, including ophthalmological examinations, and in arranging for such examinations and in administering or supervising screening tests to discover visual defects and eye disturbances.
5. To note evidences of normal and abnormal ocular functioning, referring to the physician individuals presenting evidences of deviations from normal.
6. To teach scientific health facts and practices related to the health of the eye. Some of the points for emphasis are:
 - a. The relation of normal eye functioning to (1) general health (2) nutrition (3) practices in the use of the eyes in health and in illness.
 - b. Protection of the eyes from injury and infection.
 - c. First-aid principles and practices as applied to eye injuries.
 - d. Resources for authentic eye health information.

¹ Mumford, Eleanor W. "A Program for Staff Education—Eye Health." *PUBLIC HEALTH NURSING*, February and March, 1940, p. 112, p. 197. Available in reprint form from the National Society for the Prevention of Blindness, 50 West 50 Street, New York, N.Y.

² Johns, Ethel, and Pfefferkorn, Blanche. *An Activity Analysis of Nursing*. Committee on the Grading of Nursing Schools, National League of Nursing Education, 50 West 50 Street, New York, N. Y., 1934.

³ "Functions in Public Health Nursing." *PUBLIC HEALTH NURSING*, November 1936, p. 732.

*Members of the Nursing Advisory Committee are Katharine Tucker, chairman, Naomi Deutsch, Elinor D. Gregg, Mary B. Hulsizer, Joanna Johnson, Pearl McIver, Josephine McLeod, Cora Shaw, Ruth Sleeper, Marguerite A. Wales, and Eleanor W. Mumford, associate for nursing activities, National Society for the Prevention of Blindness.

mation and for care of ophthalmological and related systemic conditions.

7. To help to secure adjustment of visually handicapped individuals through:

- a. Interpreting to the patient, family, school, or industrial personnel, or social agency the problem and its relation to general physical, mental, and emotional health and its social implications.
- b. Assisting in the adjustment of educational, recreational, and vocational conditions to meet the needs of the individual.
- c. Developing, maintaining, and utilizing community resources for the visually handicapped.

8. To help to prevent and minimize damage to the eyes from disease, injury, and infection, through:

- a. Discovering individuals with eye conditions and related health problems, and helping to secure early diagnosis and medical care.
- b. Rendering or securing nursing care of the sick and of those suffering from ocular disturbances.
- c. Teaching by demonstration and supervising care given by relatives or attendants, giving due consideration to (1) eye manifestations of systemic disease (2) systemic and local symptoms of ocular disturbance (3) protection of the eyes from infection and injury and from strain during illness and convalescence (4) adjustment of factors which favor eye comfort with special attention to conditions of close eye work during illness.
- d. Assisting in the prevention and control of infections and of communicable diseases which affect the eyes; encouraging early immunization, early medical diagnosis, isolation, and adequate care throughout illness and convalescence.
- e. Assisting in the prevention and control of noncommunicable diseases which affect the eye; encouraging periodic physical examinations, including ophthalmological examinations.

POINTS FOR EMPHASIS

Through the application of these functions, the following points should be emphasized, in both the preventive and curative aspects of programs for maternal health, for the health of infants and pre-

school children, for the health of school children, and for the health of adults.

1. Maternal health

- a. Nutrition.
- b. Elimination of accident hazards in the home and the relation of lighting and vision to accidents.
- c. Early discovery and adequate care of toxemias of pregnancy.
- d. The prevention and control of syphilis and gonorrhea.
- e. The prevention and control of ophthalmia neonatorum, including the use of an adequate prophylactic, prompt reporting, early medical and nursing care.
- f. The significance of hereditary factors and the early discovery of abnormalities in newborn babies.

2. The health of infants and preschool children. The following aspects should be emphasized:

- a. Normal eye functioning and the development of muscle coordination; early medical care for children whose eyes do not appear to function normally.
- b. Practices in use of the eyes which recognize the status of normal eye development in children of this age.
- c. Development of methods for discovering children in need of ophthalmological care, including observation and simple screening tests.
- d. Periodic health examinations, including examinations of the eye; correction of defects.
- e. Nutrition.
- f. Preventing eye accidents; encouraging use of safe toys.
- g. First aid in eye injuries.
- h. Prevention and control of communicable disease, including immunization and particular consideration to the care of the eye in the acute communicable diseases, and to the eye aspects of late-developing congenital syphilis.
- i. Safeguarding the eyes of children from strain during convalescence from illness.

3. The health of school children. All that is included under the health of infants and preschool children should be applied also to school children. In addition, special consideration should be given to:

- a. A school environment which is safe and conducive to favorable practices in the use of the eyes; provision of visual materials suitable to the normal eye development of children of school age, proper lighting, and adequate safety devices.
 - b. A curriculum which recognizes the developmental factors of eye health and provides opportunities for children to develop habits favorable to eye health.
 - c. A health service which assists in the discovery of eye problems and related general health problems of individual children and helps parents to arrange for needed care.
 - d. Adjustment of educational and recreational programs and facilities for visually handicapped children.
 - e. Interpretation to parents and teachers of the mental and emotional aspects of visual handicaps.
 - f. Elimination of eye hazards in schools and playgrounds and provision of adequate safety equipment.
4. The health of adults. The points which are enumerated below should receive special consideration in colleges and industrial health services as well as in other services to adults.
- a. Periodic health examinations, including examination of the eyes; correction of defects.
 - b. Danger to eye health from
 - (1) Focal infections.
 - (2) Communicable diseases, especially tuberculosis, syphilis, and gonorrhea.
 - (3) Noncommunicable systemic diseases such as nephritis, diabetes, cardiovascular diseases.
 - (4) Injuries and burns.
 - (5) Irritants such as heat, dusts, and other industrial hazards.
 - (6) Chemicals, drugs, and other types of poisoning.
 - c. Adequate safety devices for the prevention of eye injuries.
 - d. First aid in eye injuries.
 - e. Environmental factors conducive to safe, comfortable, and efficient use of the eyes, including adjustment of lighting to visual needs; selection of visual materials.
 - f. Emotional and social aspects of visual handicaps and adjustment of handicapped individuals; correlation with programs for rehabilitation of the handicapped.

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NURSE PLACEMENT SERVICE



announces the following placements and assisted placements from among appointments made in the various fields of public health nursing. As is our custom, consent to publish these has been secured in each case from both nurse and employer.

*Mrs. Lulu St. Clair Blaine, Executive Secretary and Director of Bureau, Michigan State Nurses Association, Detroit, Mich.

*Dorothy Campbell, Supervising Nurse, Battle Creek City Health Department, Battle Creek, Mich.

Mary C. Matthews, Supervisor, State Department of Public Health, Cheyenne, Wyo.

*Mrs. Edna S. Gould, Family Health Coun-

sellor, W. K. Kellogg Foundation, Battle Creek, Mich.

*Zimrode Eaton, County Nurse, Shelby County Sanitarium Board, Shelbyville, Ill. Margaret Daughters, Staff Nurse, Red Cross Visiting Nurse Service, Akron, Ohio.

Dorothy Lasch, Industrial Nurse, Amalgamated Life and Health Insurance Company, Chicago, Ill.

Ellouise Rothlisberg, Temporary Industrial Nurse, Container Corporation of America, Chicago, Ill.

ASSISTED PLACEMENTS

*Portia Irick, Supervising Nurse, San Miguel County, State Department of Health, Santa Fe, N. Mex.

*Viola Franz, Staff Nurse, Territorial Board of Health, Honolulu, T. H.

*The N.O.P.H.N. files show that this nurse is a 1940 member.

A Coöperative Plan for High Schools

By HELEN A. CARY, M.D.

This program of coöperation between the schools and the local medical society in Portland, Oregon, suggests a pattern which is applicable in other situations

A PROGRAM for physical examinations of high-school athletes in the Portland schools has made possible a more adequate health service for all secondary-school students. In the past only a limited number of students in secondary schools could be offered physical examinations because of the small medical staff. By coöperation with the local medical society, about 4000 additional students are now able to receive physical examinations in high school.

In the spring of 1938 the Board of Education of the Portland Public Schools appointed as director of health, physical education, and recreation a man especially trained in this field. Prior to this time, there was no coördinated health education and recreation program in the high schools. Each high school had organized its own activities. The new director became supervisor of the citywide program.

A conference which included the athletic coaches of all high schools and the Committee on School Health of the local medical society was called by the new director. The group recommended to the Board of Education that students participating in competitive sports be required to pass a medical examination for physical fitness before they are granted permission to take part. The problem of injured students was also discussed. Previously each high-school coach had made independent contracts for the care of students injured while taking part in competitive sports. It

was decided that an amount of money equal to that paid the previous year by each school was to be deposited as a lump sum to provide medical care for such students. Any student who was hurt in sports was to have the privilege of selecting his own physician to attend him. A record of all medical services was to be sent to the secretary of the medical society upon the discharge of the patient. The physician was to receive his pay at the close of the season. These recommendations were approved by the Board of Education to take effect in the fall of 1938.

JOINT PLANNING

The Division of School Hygiene was inadequately staffed to carry out the new plan for physical examinations and there was no money available in the budget to meet the need. Conferences were held by the director of health, physical education, and recreation with the chairman of the Committee on School Health of the local medical society, at which time arrangements were made to have the examinations conducted by the local members of the medical society on a voluntary basis until a more satisfactory arrangement could be made. Later, arrangements were made for a fund in the budget to pay the physicians a \$5 fee on a clinic basis for their work. Plans were made so that physicians could give examinations at each high school before the opening of the fall term. Clinics were to be held throughout the year according to the seasonal sport

and would necessitate an intermittent examining program. Physicians would be called as needed.

The program called for coöperative planning, and conferences were held with the health officer, the director of school hygiene, the director of health, physical education, and recreation; and the chairman of the Committee on School Health of the local medical society attending, to draw up policies and procedures which would be mutually agreeable to all. It was decided that the responsibility for the conduct of the clinics should be delegated to the Division of School Hygiene. The coaches of the individual schools were to be responsible for making contacts with the students to be examined and referring them to the nurse so that she could organize the clinics. The medical society through its secretary was to furnish the Division of School Hygiene with a list of physicians who would be interested in participating in such a program.

The type of examination was discussed. It was decided that the examination was to be the same as that given to all students by the school medical staff. In addition to the usual objectives of such an examination, it would serve to screen out those students who gave evidence that competitive activity might be detrimental to their immediate health or to their future growth and development. The examination was to include consideration of the following: vision, hearing, nose, throat, teeth, lymph glands, heart (including an exercise tolerance test), chest, hernia, blood pressure, endocrine glands, structural function, nutrition, and general well-being.

Each physician who conducted medical examinations at the school was to discuss the findings with the student, pointing out the desirability of having corrections for defects, or if the student was rejected for competitive athletics, explaining the reason. An effort was to

be made to see that the examination was educational to the student as well as fact-finding to the physician. It was believed that students who understood the reason for the physician's recommendations would more willingly comply with the requirements and would understand the value of good medical examinations.

HOW IT WORKS

The program is carried out in the following manner. Before students report for practice for seasonal sport, the coach sends the nurse a list of students to be examined. The clinic date is set by the nursing supervisor. In preparation for the clinic the nurse fills in all pertinent information on physical finding cards for each new student, and brings the health histories up to date. The height, weight, age, findings of recent vision test and hearing test, and pulse are recorded. Plans are made with the school office for the students to be called from their study periods on the day of the clinic.

The list of physicians' names as furnished by the medical society is consulted and the physicians are called in rotation. The first time after arrangements are made by telephone for a physician to attend a clinic, a confirmatory letter containing a copy of the policies governing the program, a copy of the special card for reporting findings to the family physician in case of abnormality, a copy of the physical findings card, and the date and the address of the school is mailed to the physician.

On the morning of the examination the nurse prepares the clinic. She introduces the student and physician and gives the physical finding card to the physician.

When students are found to have physical defects either in regular or competitive athletic examinations, the follow-up procedure is the same. A continuous program of supervision by the school nurse is planned for each student

needing help, insofar as this is possible. The school nurse makes contacts with the student's adviser and classroom teachers to inform them of any special problems so that the instructors may understand the needs of the student. Home calls and contacts with the family physician are made by the nurse when it is necessary to follow up students needing medical attention. Many times the problem may be solved by frequent conferences between the nurse and student. If the student is in his first or second year, recommendations in regard to physical activity are referred to the physical education instructor in that department, but if the student is in an upper class, this is not possible since physical education classes in Portland Public Schools are limited to the first two years. Attention is given upper-class students through student-nurse conferences, home contacts by the nurse, and adjustment of the school program when necessary. Any marked deviation from the normal in any of the findings eliminates the student from competitive athletics until further study is made by the family physician—or in case of students from indigent families, by the outpatient clinic of the medical school.

It was recognized that a student might be rejected for certain activities by the physician examining him at the school and upon complete check-up by the family physician might be considered

physically fit. To meet this situation, cards were prepared so that when a physician making an examination at school found a condition which would seem to be cause for rejection, he could fill in a form letter to the family physician stating his findings and his reason. On the reverse side of the school card is a place for the family physician to note his findings and grant permission for taking part in competitive athletics if the student is found to be physically fit in the light of further study.

Reports of all follow-up contacts are made at the close of the competitive athletic season so that records may be compiled as to findings and what has been done about them. A summary of the program for the year is prepared and furnished to the medical society.

This has been a satisfactory coöperative program which has received the support and assistance of the local medical society. Although their participation in the school health program is limited to the examination of a selected group—*i.e.*, those wishing to enter certain sports—it has added to the schools' facilities for health service and made possible a more complete health supervision of all. It has moreover stimulated the interest of local physicians in the health of secondary school students. A large part of the success has been due to the splendid efforts and hard work of the regular nurse serving the students.

THE AMERICAN JOURNAL OF NURSING FOR OCTOBER

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A Study of Industrial Nursing Services

This report of a survey of industrial nursing in a Pennsylvania county points to the very pressing need for setting standards in this field

A STUDY of 42 industrial nursing services in Allegheny County, Pennsylvania, was undertaken in the spring of 1939 at the request of the Program Committee for the annual meeting of the Public Health Nursing Section, American Public Health Association. Since so little is known about actual practice in the industrial nursing field, the meeting in Pittsburgh seemed to present a favorable occasion for making a study of practices in this great industrial area.

The committee which made the study was selected from the membership of the Public Health Nursing Section of the A.P.H.A., and was representative of many interests and sections of the country.

The schedule* used was in the main a modification of the plan drawn up by the National Organization for Public Health Nursing for studying industrial nursing in individual plants.

It was decided that personal interviews with nurses, safety directors, and plant physicians would be a much more effective means of securing the desired information than mailing the questionnaires to be filled in and returned. Accordingly, letters were sent to all the companies that were known to employ industrial nurses, asking permission to interview the interested persons in their plants. Four local people familiar with the purposes of the study were selected to do the interviewing.

*Mr. W. Graham Gole of the Metropolitan Life Insurance Company, as well as the various members of the study committee, gave most helpful suggestions concerning the questionnaire.

There were 42 companies (2 having two plants each) to be visited.* All but two companies cooperated in the survey. We have, therefore, information on 40 companies and 42 plants. These organizations were most gracious in offering to help in any way they could.

The plants included 25 heavy industries, 6 department stores, 4 banks, 4 public utilities plants, 2 food preparation plants, and 1 life insurance company. The total number of employees represented was about 100,000, of whom 84,000 were men. There were 85 nurses—81 full time and 4 part time—on duty. Three of the full-time nurses were men. The smallest plant was a bank, with 230 employees. The largest was an industrial plant with 12,000 workers. The committee believes this is a representative group.

The first medical service among the companies studied was one established in 1880; the latest was set up in 1938. In the early years, the nursing service was usually established a number of years after the medical service, but since 1910—with very few exceptions—they have been established simultaneously.

In 40 of the 42 plants, the nursing service was supported and administered by the company. In 1 plant, the insurance company through which the plant carried liability insurance maintained the

*For the purposes of this study a *company* is an organization doing business in one or more plants. A *plant* is an organization occupying a building or group of buildings in close proximity. The medical services in different plants of a company, although responsible to a central administration, may be quite dissimilar due to differing conditions in the plants.

service; in 1 plant the service was carried on under an employee group plan, with company coöperation.

Twenty-five of the companies reported that their nursing service was either stationary or dependent on business conditions to determine its future. In 14 companies the program was expanding, in 12 instances the expansion being due to the increasing use of the service by the employees and a broadening of the functions of the service. One company did not answer the question in regard to expansion of service.

If the Pittsburgh area presents conditions which are typical of the country as a whole, it is evident from the facts revealed in our study that there is a tremendous variety in industrial nursing practices.

Lack of uniformity is the most evident fact brought out by the study, and this in itself is important. When a professional service so vital to industrial life, after a quarter of a century of growth and development finds itself in such a confused condition, it is evident that something needs to be done.

FUNCTIONS OF THE NURSE

The interviewers who talked to personnel managers, safety directors, physicians, and nurses to collect information about industrial nursing in this area found each plant, store, and office a world of its own and a law unto itself in the matter of industrial nursing practice. In one plant with excellent hospital equipment and a fine medical staff, the nurses are primarily laboratory technicians. Two nurses punch time clocks and are paid on an hourly basis; and one of them relieves at the switchboard—for which she is paid a lower hourly wage than she receives for her nursing work. In more than one firm, the nurse's main function is that of truant officer; in another she is practically a full-time private secretary. And so it goes, through a long range of sundry duties.

In some respects, of course, there is a measure of uniformity. But it is not sufficient to make the programs as a whole comparable. In 27 plants the nurse assists the physician with examinations and other routines, and in 4 others she assists with examinations of women employees. In 30 plants the nurse may remove ill employees from the job, and in 24 cases she approves their return to work. The nurse gives care to sick employees who become ill in the plant, in 39 plants. This care is on an emergency basis, however, and patients are referred to private physicians for further treatment.

In only 9 plants does the nurse inspect for sanitation. In 5 out of the 40 she gives regular health instruction; in none are there any classes held. In only 5 plants the nurse is a member of the safety committee, and in 29 she is not a member of any committees. The nurses in 6 plants give nursing care and health supervision to workers in their homes. Only 2 give nursing care to members of workers' families. In 32 plants, the nurse is under direct medical supervision, although in 7 cases this is only part time.

EMPLOYEES PER NURSE

There is a wide variation in the number of employees per nurse. The smallest number of employees served by a full-time nurse is 230—all of them office workers. At the other extreme is a steel mill with 5000 employees, served by two nurses.

RECORDS

Nowhere is there more variation and confusion than in the matter of records. In some establishments, there is no record of the nurse's work other than a day sheet or day book, in which are listed the names of those who come to the hospital for treatment. Sometimes the department in which the employee works, the diagnosis, the treatment, and

other points of information are noted; sometimes not. But in these companies there are no individual records for employees except, perhaps, on serious accident or illness cases. In other instances, however, the record systems are quite elaborate and present a real difficulty to a busy nurse who has little time in which to record the required information.

PERSONNEL POLICIES

It is difficult to say what the lowest

salary is, since some of the information was rather indefinite. Answers such as "comparable with the rate for private duty" do not give a specific idea about the salary. The lowest amount actually recorded, however, was \$20 a week; the highest was \$250 a month. Thirty-four of the companies have no regular schedule of increases for the nurses, and 37 make no salary adjustment for special training. The following table gives a summary of the information secured:

MINIMUM AND MAXIMUM SALARIES FOR INDUSTRIAL NURSES IN 42 PLANTS IN ALLEGHENY COUNTY, PENNSYLVANIA, SPRING 1939

Minimum salaries	Total plants	Maximum salaries								Not stated
		100-119.99	120-139.99	140-159.99	160-179.99	180-199.99	200-219.99	220-239.99	240-259.99	
Total plants	42	1	4	6	7	—	3	—	1	20
Less than \$100	3	—	2	—	—	—	—	—	—	1
100-119.99	8	1	1	3	1	—	1	—	—	1
120-139.99	11	—	1	2	4	—	—	—	—	4
140-159.99	6	—	—	1	1	—	2	—	1	1
Not stated	14	—	—	—	1	—	—	—	—	13

Thirty-three companies allow the nurse two weeks' vacation with pay. Sick leave policies are in general quite liberal. One company allows two weeks' sick leave; another allows two weeks every six months. Twenty-four companies adjust the time allowed for illness on an individual basis; and 9 others allow almost unlimited time. There are 5, however, which make no salary allowance for sick leave. In all but 5 companies there is some provision for insurance or pensions, or both.

USE OF COMMUNITY RESOURCES

The extent to which nurses in industry utilize community resources—especially *health* resources—was of particular interest to the committee making this study.

There is practical unanimity in referring employees who are ill to private physicians. In most cases even minor illnesses are not cared for at the plant except on a temporary basis. Some companies, of course, assume responsibility

for care of illnesses and accidents occupational in origin, referring all others to family physicians.

As for clinics, a half-dozen companies reported good coöperation with these community agencies, but there was little specific information about the methods used. In any event, the nurses in most of these plants have little to do with the referrals. The plant physician usually assumes the responsibility. In most cases, there is no plan of relationship between the plant and dispensaries; referrals are made only in special cases, or (in 15 companies) are handled entirely by the family physician.

There was evidence that at least three-fourths of the firms were attempting to coöperate with official health departments in the control of communicable disease, although 3 firms gave no information on the question, and 6 others indicated that there was no plan of coöperation. In 16 plants, a release slip from the health department is required before the employee may return

to work. In 9 others, contacts are examined, either by the company doctor or private physician. (In some of these plants a release slip is also required.) In 1 plant the health department laboratory facilities are used in making serological tests on new employees. In still another, the nurse gives the family instructions on quarantine regulations when the quarantine is reported by the health department; and the nurse takes throat cultures, the tubes and laboratory service being supplied by the health department. Five companies say they use health department facilities "when indicated."

In 41 plants, the home nursing needs of the employees must be met almost entirely by an outside agency. In only 1 instance do the company nurses regularly give nursing care in the homes, although in 7 others the service is rendered on rare occasions. There is little evidence, however, of coöperation with the Public Health Nursing Association which gives bedside nursing and health supervision in the homes. In fact, some of the industrial nurses were evidently unaware of the existence of the agency and uninformed regarding its functions. Only 13 plants routinely refer employees for nursing care, and 6 others do so "when need is indicated"—which means rarely. In 12 plants, there is no referral of employees to the public health nursing agency. One large plant which carries group insurance with a nursing privilege actually discourages the use of the nursing service. Two companies gave no information on this point, and 2 others leave the matter entirely to the private physician. For the rest, coöperation, if any, is limited to giving the employee information about the service if he requests it, or perhaps advising its use in cases of severe or protracted illness. Obviously, where there is no use of the bedside nursing service, the subtler and less obvious forms of coöperation can hardly be expected.

SOCIAL PROBLEMS OF EMPLOYEES

With social agencies, private or public, in the community, there is practically no evidence of coöperation in most plants. Two firms reported close working relationships with social agencies, and in 4 instances referrals, if any, are made through a department other than the medical service. Two firms gave no information and 15 reported no coöperation whatsoever. The rest of the answers were indefinite. Many firms regard any attempts to deal with social problems as interfering in the private affairs of the employees. In most instances, too, the companies regard social problems as synonymous with financial problems, and several have plans whereby employees may receive temporary financial help from the company. Many of the nurses seem to feel that as long as they listen to the "hard luck stories" of the employees in a friendly, interested manner, and offer what advice they can, they are doing their part in the solution of social problems.

Those members of the study committee who have had occasion to request information or other assistance from any of the firms in this study know that they are most coöperative and helpful. They are actively interested in community health programs and in the work of many of the social agencies. Yet so many of them do not refer their employees for service. Granted that in many firms the actual referrals may be the responsibility of the personnel department or of some specialized worker, nevertheless the nurse has an important role to play. She is in a strategic position to recognize needs, not only from the health standpoint but in other respects as well. However, in order to function effectively in this capacity she must not only be aware of the work done by community agencies, but must be able to recognize individual problems and to analyze them so that she may call upon the agency best

equipped to help the employee. In this connection it is interesting to note that only 9 of the 85 nurses in the survey were members of the State Organization for Public Health Nursing, and only 3 were members of the National Organization for Public Health Nursing.

NEED FOR PROFESSIONAL STANDARDS

The facts revealed in this study—the lack of uniformity in essential points of the program, and the apparent unawareness of the importance of community resources—point to a definite lack of public health standards and training in the profession of industrial nursing. In this connection the qualifications for employment of nurses which have been set up by the various firms are of interest. In all but one plant the nurse must be a registered nurse; but 10 require nothing more than this. Five others rely greatly on hospital background and other nursing experience. Several require that the nurse be “motherly,” and 5 specify maturity in years as being essential—the idea being that the employees will not confide readily in a younger woman. Only 1 firm requires experience or special preparation in the field of industrial nursing.

Let it not be supposed that there is no place in this great industrial area where there is an adequate, satisfactory nursing service. There are, indeed, several companies where the management, the physicians, and the nurses are not only cooperating in carrying on commendable medical programs, but are alert to new developments and eager for progressive change. For the most part, however, industrial nursing has failed to realize its possibilities.

WHOSE RESPONSIBILITY IS IT?

For this situation industry itself cannot be blamed. It cannot be expected to know that a nursing program should do anything more than render

first aid and fulfill the requirements of safety regulations. (In several instances, however, the personnel managers and other company executives expressed the wish that the nurse would carry more responsibility for real health supervision than she was doing.) Industry does its part when it employs the nurse, provides her with equipment, and gives whatever cooperation she may need. In fact, if industries suddenly demanded well trained industrial nurses, where would they get them?

The setting of standards in the industrial nursing field and the education of industry to the importance of those standards are the responsibility of the medical and nursing professions. We mention the medical profession because so frequently the physician determines the policies of the entire medical department. The physicians interviewed during the survey were of many shades of opinion. One can see, for example, where initiative and alertness might be a handicap to a nurse if her immediate superior were the physician who wanted to know what a nurse could do to aid in the examination of a male employee, or the one who scoffed at the idea of further education for nurses. On the other hand, there are physicians who place a great deal of responsibility on the nurses and are thoroughly interested in developing a progressive, vital program.

But the key person in the whole situation is the nurse herself. It is her responsibility to educate her superiors, the company executives as well as the physician, to the potentialities of her job. Furthermore, in many industries the nurse is not under constant medical supervision. In 17 of the plants studied she is largely her own boss, and in several cases where there is a full-time physician, the nurse is nevertheless practically a free agent. These facts place still more responsibility on the nursing profession.

We do not mean to point an accusing finger at the industrial nurses who are at present on the job. For the most part, transplanted from the hospital or from private duty, they have made the best they could of this job in industry. They have fulfilled surprisingly well the functions required of them. That these functions are limited is due to factors not always within their control.

Rather do we place the responsibility on the nursing profession which is just beginning to recognize the peculiar responsibilities and opportunities of industrial nursing, and to fulfill its obligation to give nurses adequate training to meet the challenge which industry offers.

It is true that health and social agencies could do a better job in educating industries as to their community responsibilities, but the education of the industrial nurse as a community worker is a more rapid, more economical, more effective way of bringing about the coöperation between industry and community agencies which is essential to optimal community welfare.

A high degree of development in coöperation between industry and community agencies is shown in the following story:

An industrial nurse with several years' experience as a public health nurse referred Mary Brown to the Pittsburgh Public Health Nursing Association for home care, since absence from work denoted possible illness. Mary's work record showed declining efficiency during recent weeks and the nurse had

noted signs of poor health, although Mary would not admit having any physical difficulties.

The nurse found that the girl was indeed ill, but it was evident that the illness was more mental than physical. Sleeplessness and uncontrollable tears gave the clue. Investigation with the help of the mental hygienist on the staff of the nursing association revealed that the break had been caused by an overload of responsibility at home, coupled with a series of reverses, the last being a transfer from one department of the company to another where she was not happy. This last had been the "straw that broke the camel's back."

Now, with the coöperation of the visiting nurse, the industrial nurse, and the personnel manager of the company, plans are under way to place Mary in a position in the industry where she will be happiest and consequently most efficient. The family has been referred to a social agency, which is taking steps to make helpful adjustments in the home situation. A happier family, a more efficient employee, and the removal of the source of a community problem are the results of this coöperation between industry and community agencies promoted by a well trained, alert industrial nurse.

It is true, certainly, that industry is a difficult field to penetrate. Unlike the schools and health departments, the business world is a place in which the general public has nothing to say about nursing standards. Industry has seemed very like an impregnable citadel. And because this is true, perhaps it has seemed wisest to concentrate on raising standards in other fields of nursing before entering on this particular one. But there has been too much delay. Industry is ready. Let nurses meet its challenge and accept its responsibilities.

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Your N.O.P.H.N.

"Hello, Ann, don't you know it's lunch time? Why not come along with me and while we eat tell me what you have had your nose so buried in. I haven't had time for even a peek at PUBLIC HEALTH NURSING magazine."

"Thanks, Mary, let's be off, but you'll get fooled if you expect to hear about the latest thermometer technique. Because what do you suppose I've been reading? The N.O.P.H.N. treasurer's biennial report. It started with a story—maybe that's what caught my eye! Whee, I'd hate to have that man's job! I have a bad enough time with my own tiny budget, but just imagine worrying about a \$100,000 budget."

"Yes, but you and I have to raise our own budgets by the sweat of our brows, and I might add, by the charley horses in our legs, whereas the N.O.P.H.N. is a corporation (haven't you noticed the Inc.?) and is owned and operated by its thousands and thousands of members. Actually every last one of us shares with the treasurer the budget responsibility."

"The plan for enrolling members and securing subscribers for PUBLIC HEALTH NURSING is certainly a coöperative plan. Do you recall that membership talk at our S.O.P.H.N. meeting? It was made by our state membership representative, whose responsibility it is to remind public health nurses and lay persons interested in our work of the advantages to be gained by keeping their membership up to date. There's a state membership representative in every state, and also in Alaska and Hawaii. They are appointed by the chairman of the National Membership Committee to serve for two years."

"One of the girls was telling me about the hilarious time the state representatives and members had at the Rally at

the Biennial. She said the National Chairman was grand—made everybody feel like one big family. And she said she couldn't help hoping that someday she'd be asked to serve as a state membership representative and have an opportunity to take a really active part in helping with the enrollment."

"Come to think of it, \$3 isn't much to pay as dues when it assures us of a place to turn to for help. Don't tell, or the N.O.P.H.N. will go broke, but I just got \$4.35 worth of reprints without paying a cent, because I'm a member."

"Yes, and besides that you're getting PUBLIC HEALTH NURSING at the \$2 rate for members instead of the regular \$3, so that saves another \$1. Oh, Ann, you're Scotch all right!"

"Dues of \$3 from 10,500 members makes a total of—let's see—\$31,500. Why, that's only about a quarter of the total budget. Here I was feeling that our dues practically made up the total."

"Well, that's where I can fill in, having just read the treasurer's report. Only one quarter of the total budget comes from individual dues. The other three quarters come in almost equal parts from contributions, agency dues, and the magazine—subscriptions and advertising. There are a few miscellaneous sources, but they don't amount to enough to try to remember what they are."

"You know, Mary, when I had my first V.N.A. job I thought I didn't need to be an individual member because my association was an agency member. It wasn't long, however, before my supervisor explained that the privileges of agency membership differed from those available to individual members, and besides, that it was the privilege and responsibility of every public health

nurse to belong to her own national organization. Believe me, I sent my dues right straight off because I was particularly interested just then in getting a ballot so I could take part in the election of the N.O.P.H.N. board that was about to take place. Also, I wanted an N.O.P.H.N. pin.

"I felt pretty smart that year. I went to my first Biennial and was able to walk right in to the N.O.P.H.N. closed business sessions by presenting my membership card. You know, I have the most comforting feeling about possessing my membership card—it's almost as comforting as my savings bank book. Come to think of it, I get interest on both when I remember all the ways the National is constantly helping me."

"Yes, and I'm grateful to the people—I guess they're mostly lay persons—who contribute to the N.O.P.H.N., because actually their money buys service for us, doesn't it?"

"That's probably just the reason the treasurer, in his report, asked each of us to try to get a new contributor for the National Organization.

"Wouldn't you like to be able to visit the office of the N.O.P.H.N.? I feel fairly well acquainted with the executive staff because I've seen most of them at Biennials or when they have been on field trips but I'd really like to see the wheels go 'round in the business office. Taking care of 20,000 membership and subscription records would be a neat little job, wouldn't it? And think of the entries in the daily cash book—hundreds of checks for \$3 and then all the little

ones for reprints, posters, et cetera. And we think we have records to keep!"

"How would you like the job of being the business manager and managing all that business?"

"Yes, and how would you like to type all the letters that have to be answered? I don't imagine they use the hunt and peck system!"

"You make me almost ashamed of the letter I sent yesterday asking a million questions. I asked for suggestions for reading material on lay participation in the public health nursing program for the report I have to give at staff meeting. Then I gaily went on to ask for information for my little hospital friend who has been hounding me to tell her the best way to get prepared for public health nursing. She wants to know requirements for various positions and what salaries are paid. To tell you the truth, I couldn't answer her but I know the N.O.P.H.N. will send me just what I need so I can be sure I am giving her the best advice. As a matter of fact, I'm interested for myself, too, for I dream of being an educational supervisor some day."

"Well, Mary, I must run. See you at staff council meeting tonight. By the way, how about telling the group some of the things we have been talking about? Maybe we might even think up a way to interest some of our lay friends in becoming members or contributors of the N.O.P.H.N."

LUCRETIA H. ROYER
Business Manager

The N.O.P.H.N. is a membership organization and that fact of membership influences all that we do.

Grace Ross, President, N.O.P.H.N.

Requests have recently been received for key rings like the ones which were given as favors at the N.O.P.H.N. Membership Rally luncheon at the Biennial Convention this year. These rings bear the official N.O.P.H.N. seal. If a sufficiently large number of orders is received, we can make these key rings available at 25 cents each, reordering a new supply from the manufacturer. Please let us know if you are interested.

NOTES *from the* NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

Lillian D. Wald

THE DEATH of Lillian Wald has taken from our ranks a vital personality and a leader of incomparable achievement, but the spirit and inspiration so warmly implanted in the hearts and minds of American nurses will live on through the years. Miss Wald has been referred to as social worker, publicist, humanitarian, and statesman. Her work in the national and international field of social welfare has made her name known throughout the world.

Her influence on nursing began with her visit to the first Henry Street patient, so vividly described in *The House on Henry Street*. Much that forms the basic principles of public health nursing today could be found in the handling of that first family situation and all that grew out of it. Her analysis of the situation is summed up in her own words: "All the maladjustments of our social and economic relations seemed epitomized in this brief journey and what was found at the end of it. . . . That morning's experience was a baptism of fire . . . To my inexperience it seemed certain that conditions such as these were allowed because people did not know, and for me there was a challenge to know and to tell. . . ."

Perhaps this is the keynote of all that Miss Wald was able to bring to the millions into whose lives her work brought new hope: that she was sensitive to conditions, that she was able to see around and through situations, and that she could make others see and feel as keenly as she did the injustice to human beings and the disgrace to a great country when such conditions were allowed to exist.

To those who had the privilege of close association with her, there was always a rekindling of zeal and strengthening of insight through contact with her rare personality. Her great emotional appeal gave to less gifted fellow workers a lift in the drive for better things. The type of leadership which Miss Wald represented belonged peculiarly to her time. Through group thinking and planning, the leaders of today are able to accomplish much, and progress for human betterment in which nurses play an important part goes steadily on. But the leadership of Lillian Wald was that of the pioneer who blazed new trails alone. Her genius as an individual leader pointed the way for all whose imaginations were stirred by her high purpose.

As early as 1912 when the need for a national organization for public health nursing was recognized and plans were formulated, Miss Wald was well known for her ability and statesmanship. As Mary S. Gardner expressed it: "Miss Wald, with whom we consulted, gave us excellent advice and was a rock to lean on. . . . her name and backing simplified everything . . . Miss Wald's reputation and the fact that we wanted to make her our first president carried more weight than I think we realized at the time." Her presidential address at the opening meeting of the N.O.P.H.N., reprinted in this magazine during the Organization's twenty-fifth anniversary year (June 1937 issue), shows her farsighted realization of the possibilities of our profession for social good.

Is it any wonder that to the very end of her life people sought her out for advice, for help in need, for renewal of

courage, and to catch a little of that great vision of a better society which she gave to all who came in contact with her.

During the last years when she was removed from active life because of illness, her charming Saugatuck home was the Mecca for thousands who still sought her help. Her interest in nursing remained, her enviable skill in pointing the "right way." Those of us who knew her like to think of her as Robert L. Duffus so sympathetically describes her in his biography (*Lillian Wald—Neighbor and Crusader**), lying in bed, wakeful, looking out of her window—"Tomorrow, and dawn coming, and the trees taking shape, and, behind them, almost as vividly as though the eye could span the gap, against the Connecticut sky, the silhouette of Henry Street, and the undying memory of its dear stir and clamor."

MARGUERITE WALES, R.N.
Battle Creek, Michigan

*Published by the Macmillan Company, New York, 1938, p.355.

HONOR ROLL

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ARIZONA

Nursing Division, State Health Department, Phoenix

CALIFORNIA

Santa Rosa Chapter, American Red Cross, Santa Rosa

COLORADO

Division of Public Health Nursing, State Department of Health, Denver

CONNECTICUT

East Lyme Visiting Nurse Association, Inc., Niantic

DISTRICT OF COLUMBIA

Child Welfare Society, Washington

IOWA

Monroe County Nursing Service, Albia
Ames Board of Education, Ames
Boone Public Schools, Boone
Metropolitan Life Insurance Nursing Service, Burlington

Bureau of Dental Hygiene, State University, Iowa City
Iowa City Public Schools, Iowa City
Greene County Red Cross School Nursing Service, Jefferson
Plymouth County Nursing Service, LeMars
Monona County Nursing Service, Onawa
Washington County Nursing Service, Washington
Hamilton County Nursing Service, Webster City

MICHIGAN

Lincoln Laboratory School of Michigan
State Normal College, Ypsilanti

MINNESOTA

Chippewa Indian Health Unit, Cass Lake

MISSOURI

Polk County Public Health Nursing Service, Bolivar
Worth County Public Health Nursing Service, Grant City

MONTANA

Division of Child Welfare, State Board of Health, Helena

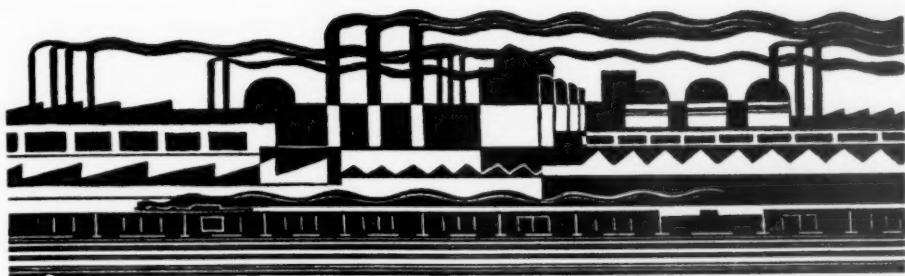
NEBRASKA

Division of Child Welfare and Services for Crippled Children, Lincoln

NEW HAMPSHIRE

Alexandria School Nursing Service, Alexandria
Bristol School Nursing Service, Bristol
Canaan School Nursing Service, Canaan
Derry School Nursing District, Chester
Danbury School Nursing Service, Enfield
Enfield School Nursing Service, Enfield
Orange School Nursing Service, Enfield
Franklin School Nursing Service, Franklin
Grafton School Nursing Service, Grafton

(Continued on page 647)



SHOULD THE NURSE BE INFORMED OF ABSENTEEISM?

HOW ARE industrial nurses informed of absenteeism of employees due to illness? Does the nurse receive prompt and adequate information on the illness of employees, so that she can keep in close touch with their health needs? These questions were discussed at a round table on industrial nursing at the Biennial Convention in Philadelphia on May 14, 1940.

Various methods of reporting employee illness to the nurse were mentioned. Frances Norquist of Seattle reported that all departments of the large store in which she is industrial nurse report absentees to the nurse daily. Employees who have been ill also report to the nurse before returning to work.

Other nurses said that the foreman of each department reports absentee em-

ployees to the nurse, giving the cause if he knows it.

It was agreed by the participants in the round table that it is important for the nurse to be informed as promptly as possible of illness among employees. Only if she has this information promptly can she do her part in protecting the health of the worker, seeing that he receives early medical attention when needed, getting him back on the job as soon as possible, and seeing that he does not return to work before he should from the standpoint of his own safety and that of his fellow workers.

Other questions discussed at this round table—which was attended by a hundred nurses interested in industrial nursing—will be summarized in this section in subsequent issues.

A NEW ENGLAND PLANT REDUCES HAZARDS

THE PRIMARY aim of the industrial nursing service of the Nashua Manufacturing Company is to reduce accidents, and particularly lost time from accidents. We have had practically no lost time from injuries since January 1940. The plant has a safety committee and each accident is investigated and steps taken to prevent a recurrence.

There are three thousand employees, of whom about 60 percent are men. There are three shifts working nearly all the time. The two nurses cover the

hours from 7 a.m. till midnight. One works from 7:00 a.m. to 4:00 p.m. with an hour for lunch; the other from 3:30 p.m. till midnight with a half hour off for dinner.

Our work is mainly first-aid treatment, subsequent dressings, and follow-up treatments. If a minor accident occurs after midnight, the nurse dresses it in the morning. If it is of serious nature, the patient is sent to a physician or hospital and later comes to the mill for dressings and follow-up care. A



medical panel of five local doctors is available at all times for the treatment of accidents, and if the injury is so serious that the patient cannot be moved, one of the doctors comes to the plant. The nursing service has a list of standing orders for emergencies.

In the pre-employment examinations of men employees, all those with any sign of hernia are required to have it corrected before they are employed. In the bleachery and dye departments, there is a standing order that heavy and middle-aged men are not to climb ladders. All machinery is well guarded, and serious accidents are being eliminated. Employees with fractures who are able to come to the mill are given some kind of work to do with the approval of the attending physician, whenever possible.

At one time the men using carbon tetrachloride in cleaning machinery developed severe intestinal disturbances resulting in at least a week of disability.

After an investigation, the plant tried using kerosene and we have had no further trouble. To prevent dermatitis of the hands from dye-stuffs, the plant managers rotate the workers. In very dusty places in the plant, the men are provided with masks.

We interview all prospective mothers among women employees and advise early medical supervision. A written statement is requested from the family physician that the patient is physically able to continue working up to the sixth month. All employees in need of nursing service are referred to the public health nursing association and from this source they receive instructive literature from the State Board of Health.

A well equipped cafeteria is provided at the plant for the use of employees.

Daily, weekly, and monthly reports are made by the nursing service to the management.

BERNICE B. LADD
Nashua, New Hampshire



EDITED BY ANNA C. GRING

THE PUBLIC HEALTH NURSE AND HER PATIENT

By Ruth Gilbert, R.N. 396 pp. The Commonwealth Fund, New York, 1940. \$2.25.

Miss Gilbert has brought to life in this book such abstract terms as attitudes, approach, emotional reactions, motivation, relationships. From her wide experience in helping public health nurses to assist individuals and families to meet their needs she has gathered an amazing number of situations which are being encountered by public health nurses everywhere in their work. From nursing case records she has selected illustrations of the methods, both successful and not so successful, which nurses have used.

For the teacher or supervisor the book provides a means of interpreting to her students what is meant by approach and teaching content in a visit; what motivation means, and what part the nurse plays in it; what are the emotional factors which make the approach to a group different from that to an individual.

For the administrator new light is thrown upon the important service a community nursing agency can contribute to family health through more intensive care of the old and the chronically sick in the home; upon the effect of recognizing good performance and additional preparation of the nurse by means of salary increases; and upon the emotional factors involved in inter-agency relationships.

As the title of the book suggests, however, it is for the staff nurse, either in the institution or in the home, that the book will be of most value, for it is she who builds a relationship with the patient.

It is scarcely believable that so much with new emphasis and practical value could be covered in one book. Perhaps because of its comprehensiveness we find somewhat disappointedly that some of its illustrations fall just short of being specific enough to give us a key to meeting a similar situation. We hope Miss Gilbert will sometime write for us a series of family studies based on her collection of nursing records.

A difficult and complicated subject has been handled with remarkable clarity and the function of the public health nurse in the area of mental hygiene at last becomes tangibly defined.

VIRGINIA A. JONES, R.N.
Honolulu, Hawaii

MODERN DIABETIC CARE

By Herbert Pollack, M.D. 216 pp. Harcourt, Brace and Company, New York, 1940. \$2.

This is one of the best of the several diabetic manuals now available. The book is interestingly written and covers the subject thoroughly. Valuable chapters on Protamine Zinc Insulin and The Technique of Handling Insulin are included. It can be recommended highly to nurses, and many physicians will find it of great help. The reviewer wonders,

however, if the subject matter is not a little too detailed for the average diabetic patient. Experience indicates that material must be presented in simple form in order to be grasped properly by the majority of patients. For patients and their relatives possessing higher degrees of interest and intelligence, Dr. Pollack's book would be excellent. As with all diabetic manuals, this book will undoubtedly be most useful in the clinic from which it originates.

There are certain statements which may be challenged. On page 48 occurs the following: "The physician may suspect the diabetic syndrome in a given case but he will never say for certain until he has given the individual a Glucose Tolerance Test or its equivalent." Actually in practice only occasionally is a glucose tolerance test necessary for diagnosis, and when carried out in the presence of definite diabetes may temporarily upset the patient's condition considerably. Usually single blood sugar estimations, particularly at 45 to 60 minutes after a meal, will settle the diagnosis. Perhaps this is implied in Dr. Pollack's words "or its equivalent" but this might not be clear to the patients reading the book.

In chapter 18, in which pregnancy in diabetes is discussed, no mention is made of the high fetal and neonatal mortality which occurs unless newer methods of treatment are employed. These newer procedures, still in the experimental stage, include substitutional hormone therapy in appropriate cases; the results so far have been most encouraging.

If this book is to be used in clinics other than that of the author, more account should have been taken in chapter 20 of the fact that many physicians believe that at the outset of treatment no better training for the patient exists than a preliminary period during which food is weighed on gram scales. If

scales with a movable dial are used, weighing is not a laborious process. One keeps in mind that the weighing of food at this stage of treatment is simply a means to an end and not an end in itself. After a period of a few weeks the eye and hand become so used to portions of food that the patient can then select his food anywhere with a surprisingly high degree of accuracy.

The criticisms made in this review do not detract from the fact that Dr. Pollack has written an excellent diabetic manual which should prove of great benefit to patients, nurses, and physicians.

ALEXANDER MARBLE, M.D.
Boston, Massachusetts

NURSING CARE OF PATIENTS WITH INFANTILE PARALYSIS

By Jessie L. Stevenson. 58 pp. The National Foundation for Infantile Paralysis, New York, 1940. Free.

This pamphlet was prepared by the National Organization for Public Health Nursing for The National Foundation for Infantile Paralysis as a part of a project in orthopedic nursing sponsored by the Foundation. It is intended to assist the public health nurse and others responsible for home care of patients with infantile paralysis, during and following an epidemic.

ECONOMIC ASPECTS OF MEDICAL SERVICES

By Paul A. Dodd and E. F. Penrose. 442 pp. Graphic Arts Press, Inc., Washington, D. C., 1939. \$3.75.

This report is a fact-finding study made possible through the joint efforts of the California Medical Association, the Federal Government, California State Dental Associations, and the California Osteopathic Association. It deals primarily with some economic aspects of the cost, distribution, and organization of medical services for those who provide and those who receive the services in California. "Such subjects as nursing

and pharmaceutical conditions have been omitted," the preface states, "not because they are relatively unimportant factors, but rather only because time and money did not permit their inclusion."

The early chapters of the book give a good picture of the distribution of health facilities, the population to be provided with health services, the needs for such services, medical charges, and the relation of family incomes to medical costs.

The middle of the book deals quite largely with medical practitioners, their incomes particularly during the depression, and various economic changes that have occurred in the organization of medical facilities.

In the latter part the discussion deals with the organization of medical services, particularly the public health situation in California, and the nature and extent of the possibilities of health insurance followed by conclusions and recommendations based on the authors' interpretations of the facts presented.

From some standpoints the most radical recommendation of the whole report is the statement that not only should there be insurance against illness but cash benefits for illness should be associated with medical treatment. And this presumably would also be handled on an insurance basis.

Of course there will be differences of opinion concerning the recommendations, which stress the necessity for a compulsory insurance scheme in order to secure complete health coverage for all in the state.

HAROLD F. CLARK, Ph.D.
New York, New York

OUR COMMON AILMENT: CONSTIPATION—ITS CAUSE AND CURE

By Harold Aaron, M.D. 192 pp. Dodge Publishing Company, New York, 1939. \$1.50.

Dr. Aaron has done a good job of writing clearly, in language which the nonmedically trained reader can understand, an account of the normal and abnormal physiologic activity of the

bowel tract. He tears down the old theories of "auto-intoxication," "alkalinization," et cetera. The many meaningless and pseudoscientific terms of the advertisers of the multitude of patent-medicine laxatives, which our gullible public uses in such huge quantities, are berated. (\$300,000,000 is spent in the United States yearly for patent medicines, many of which are laxatives.) The use of diet, the restoration of good bowel habits, and the use of enemas and laxatives where necessary are all discussed. The book is well worth reading by nurses, the general public, and doctors as well.

SELMA C. MUELLER, M.D.
Duluth, Minnesota

SUPERVISION IN PUBLIC HEALTH NURSING

Ten articles reprinted from *Public Health Nursing*, 46 pp. Obtainable from National Organization for Public Health Nursing, 50 West 50 Street, New York. 50c.

This pamphlet is a compilation of ten articles which appeared in *PUBLIC HEALTH NURSING* magazine during the past 17 years, selected to show the evolution of our present philosophy and methods of supervision. These articles were assembled by a subcommittee of the N.O.P.H.N. Publications Committee in response to a demand from the field for material on the subject in easily available form. The pamphlet includes a foreword and a list of other articles on supervision.

NEW FACTS ON MENTAL DISORDERS

By Neil A. Dayton, M.D. 486 pp. Charles C. Thomas, Springfield, Illinois, 1940. \$4.50.

The carefully compiled and precisely evaluated statistics in this book should elevate the ethical reputation of statistics. Dispassionately they tell the truth. Graphs and tables are used generously to supplement the text.

This study of 89,190 patients in the state hospitals of Massachusetts from the year 1917 to 1933 inclusive is a

memorial to George Milton Kline whose labors in psychiatry entitle him to be enrolled among the benefactors of humanity. It is a tribute to the advisory committee which supervised the work and the Laura Spellman Rockefeller Foundation and the Rockefeller Foundation that supported it.

During the World War of 1917-1918, in spite of the absence of five percent of the population who were participants in the War, the admission rate to hospitals for mental disease was 83 per 100,000 in 1917; in 1918 it dropped to 82.

The more substantial increases in admission rates occurred between 1923 and 1929 when more than a hundred thousand workers lost their jobs. In the period following 1929 nearly twice as many additional workers were laid off, yet only a slight increase in new cases of mental disorder is observed.

The comment on these figures deserves attention: "The great mass of the population possesses a mental balance that is truly remarkable. In the face of such catastrophes as a World War, widespread unemployment, and a major depression, comparatively moderate increases in mental disorders are observed. In the later years, serious social and economic developments added mental worries and physical deprivations to the lives of hundreds of thousands but increased the numbers of mental patients only by hundreds."

In this interpretation the reviewer would suggest a need of caution in any application to present times. It is exceedingly likely that the emotional stability has been somewhat decreased by a series of severe impacts, many of them critical and some of them catastrophic. It is probable that this has been expressed in terms of more minor psychoses, more maladjustments, and possibly an increased tendency to escape from reality by the routes of violence, notably the violence of war.

It would be of greatest possible value

for the psychiatry of the future if another similar seventeen-year statistical study, 1934-1950, could be undertaken. The results would provide a basis of comparison and would be an answer to the query as to whether innate resistance can call on strong reserves in order to meet terrific onslaughts.

If the human mind, statistically speaking, is able to survive the concussion of the destructive forces which it is now encountering, then the mental future of our species is adequately insured.

EDWARD A. STRECKER, M.D.
Philadelphia, Pennsylvania

THE PARTICIPATION OF MEDICAL SOCIAL WORKERS IN THE TEACHING OF MEDICAL STUDENTS

By Harriett M. Bartlett. 68 pp. Prepared for the Education Committee of the American Association of Medical Social Workers, 844 Rush Street, Chicago, Illinois, 1939. \$1.50.

This book summarizes the trend in the efforts of medical schools to stress the social aspects of medicine in their teaching and the part medical social workers have played and hope to play in their teaching program. The discussion of the methods of presenting these aspects will be helpful to those who teach groups of nurses through case-study methods.

V. A. J.

NEW MATERIALS ON MATERNITY

BIRTH ATLAS. 16 photographic plates. Maternity Center Association, 654 Madison Avenue, New York, N.Y., 1940. \$3.50.

Reproductions of 24 life-size sculptures of fertilization, growth, stages of labor, and involution. Should prove invaluable teaching aids to public health nurses participating in a maternity teaching program.

HOW DOES YOUR BABY GROW? 11 pp. Maternity Center Association, 654 Madison Avenue, New York, N.Y., 1940. 5c per copy; \$4 per 100 copies.

Illustrated pamphlet which describes the growth of the baby and reasons for essentials of adequate care during the entire maternity cycle, in words of one syllable. Excellent for lay people.

NEWS NOTES

• Winifred L. Fitzpatrick, director of the Providence (Rhode Island) District Nursing Association, received the honorary degree of Doctor of Humane Letters from Bryant College in Providence on August 9. In January 1939 the Association celebrated the thirty-fifth anniversary of Miss Fitzpatrick's service with the agency.

• October is a month of annual state meetings. We have received word of the following:

Arkansas State Nurses' Association, October 21-23.

Indiana State Nurses' Association, October 17-19, McCurdy Hotel, Evansville.

Iowa State Nurses' Association, October 2-4, Hotel Burlington, Burlington.

Louisiana State Nurses' Association, November 11-14, Bentley Hotel, Alexandria.

Minnesota State Nurses' Association, October 16-19, Lowry Hotel, St. Paul.

Missouri State Nurses' Association, October 13-16, Hotel Connor, Joplin.

Nebraska State Nurses' Association, October 8-10, Omaha.

Pennsylvania State Nurses' Association, October 22-25, Hotel Sterling, Wilkes-Barre.

South Carolina State Nurses' Association, October 17-18, Greenwood.

Tennessee State Nurses' Association, October 6-9, Peabody Hotel, Memphis.

Utah State Nurses' Association, October 11-12, Salt Lake City.

• The new president of the American Dietetic Association, Mary Isabel Barber, will take office during the week of its convention at the Hotel Pennsylvania, New York, October 20-26.

• The Mississippi Valley Conference on Tuberculosis will be held at the Lowry Hotel, St. Paul, Minn., October 2-4. The problems of tuberculosis as related to the field of nursing will be discussed at a half-day session in the afternoon on

October 4. The program on October 2 is devoted to health education of school children.

• The Nursing Bureau of Manhattan and Bronx in New York City announces the appointment of Marian Durell as executive director. Miss Durell was formerly with the University of Michigan Hospital School of Nursing.

(Continued from page 640)

NEW HAMPSHIRE

*Groveton Public Health Nursing Association, Groveton

Londonderry School Nursing Service, Londonderry

Northumberland School Nursing Service, Northumberland

Stark School Nursing Service, Stark

Wilmot School Nursing Service, Wilmot

Windham School Nursing District, Windham Depot

NEW JERSEY

*Anti-Tuberculosis League, Orange

NEW MEXICO

*Socorro County Health Department, Socorro

OKLAHOMA

Carter County Health Unit, Ardmore

SOUTH DAKOTA

Huron Board of Education, Huron

TENNESSEE

*Williamson County Health Unit, Franklin

Lauderdale County Health Department, Ripley

WEST VIRGINIA

Metropolitan Life Insurance Nursing Service, Clarksburg

WISCONSIN

Florence County Public Health Nursing Service, Florence

District No. 6 Health Office of the State Board of Health, Green Bay

Waupaca County Health Department, Waupaca

ALASKA

Cordova Department of Health, Cordova
Kodiak Department of Health, Kodiak

*Agencies which have been on the Honor Roll five or more years.

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PUBLIC HEALTH NURSING

Official Organ of the National Organization for Public Health Nursing, Inc.

The Mosaic of America Today

RICHLY HUMAN, colorful stories of foreign-born families who immigrated to America in great numbers around the turn of the century fill the early issues of this magazine. Aliens in a strange land seeking opportunities denied them in older, more crowded countries, they were frequently found in desperate situations of poverty and illness by the early visiting nurses who climbed tenement stairs to give nursing care to the sick. The struggles and the courage of these immigrants to our shores from many countries are told by the nurses in stories more deeply poignant and stirring than any fiction. Their unique contributions to our culture from their own background and customs and art were appreciated by the nurses—perhaps due in part to the inspiration of Lillian D. Wald, whose House on Henry Street gave recognition and welcome to people of every nationality and race and creed.

The great tides of immigration have stopped, with the restrictive legislation of recent years. Today we have refugees from oppression in other lands, but quantitatively the problem is a small one because their numbers are not great, compared with immigration in the past. Nevertheless, the population of our vast country is still a mosaic drawn from many cultures whose roots go back into the past and into many countries. At this time, when we are shocked by the new waves of intolerance toward minority groups in other lands, it is fitting that we should seek with renewed earnestness for a deeper understanding of

the national and racial groups which comprise our country. Certainly it is a time to safeguard, with all the influence at our command, the tradition of tolerance toward minority groups which is the very foundation of our democracy.

The article on "Jewish Dietary Laws and Food Customs" in this issue gives us a new background for appreciation of the cultural and religious roots and patterns of one ethnic group. Many other new materials are available in regard to other peoples with whom the public health nurse works. *South Italian Folkways in Europe and America*, reviewed in the April 1939 issue of this magazine, shows the problems of adjustment which the southern Italian immigrant and his children face in this country.

The refugee problem is analyzed in its many facets in a symposium on "The New Immigration to the United States," in the December 1939 issue of *Social Work Today*, with a bibliography at the end. The traditional American attitude toward oppressed peoples, the contribution that immigrants have made to our culture and economy and scientific knowledge, the character and extent of our recent immigration, the agencies that exist to help the immigrant adjust to his new environment, the attitude of organized labor toward the refugee, and the trend toward anti-alien legislation born of fear in the present world crisis—these are some of the subjects discussed in this magazine.

The challenges to democracy presented by the presence of various minority

groups in our country are brilliantly discussed in a special number of the *Survey Graphic*, "Calling America," in February 1939.

Other suggested references on the refugee problem are listed on page 706.

The refugee and his problems would provide rich material for a staff educational program whose ramifications could carry the staff into the racial and national backgrounds of the families who depend on them for nursing care and guidance. Public health nursing has as

a fundamental principle the tenet that the service should be available to all people in the community regardless of race or creed or economic status. We believe that the public health nurse with her deep sense of human values born of intimate acquaintance with the heroic struggles of people to rise above difficulties will welcome the opportunity to inform herself more thoroughly regarding the problems—old and new—of the peoples which make up America today.

P. P.

SYMBOL OF HUMANITY

THE RED CROSS speaks a universal language of humanitarian aid to all those who suffer from the catastrophe of disaster or war. During the 22 years since the World War, it has served as a medium through which the American people gave aid to the victims of disaster; cared for the needs of ex-service men and their families whom the general public had forgotten; administered public health nursing in 459 communities; utilized the work of volunteers for making layettes and dressings and relief supplies, transcribing Braille for the blind, and assisting in hospitals; carried on a vast educational program to prevent illness and accident and teach the care of the sick in the home, through classes in first aid and life-saving and home hygiene; and recruited a reserve force of qualified graduate nurses ready for any possible emergency.

Today the need for all these activities is intensified. Human suffering on an unprecedented scale calls upon the generosity of the American people for aid. We have a twofold responsibility: to give relief to the victims of war-devastated countries, and to build at home a social structure that will be strong because it meets the fundamental needs of our people for health and security. During the year from September 1939 to September 1940, more than

\$7,000,000 was spent by the Red Cross for food, clothing, and medical supplies for war sufferers in other nations. (See page 667.) The number of volunteer workers increased tenfold over the previous year. Home service to families of men in the armed forces assumes new importance with the calling of men for peace-time military training. The education of our citizens to safeguard their health and give care to their families in emergencies of illness or accident—vitally important at any time—becomes indispensable to a nation which is strengthening all its resources in the face of worldwide devastation.

More than 4000 nurses will be called to active service by the United States Army before July 1941 from the ranks of the first reserve of Red Cross nurses,* to meet the increased requirements for nursing service necessary to safeguard the health of men called for military training.

The Red Cross service is indispensable. It calls for our support, through memberships and contributions, in the 1941 Annual Roll Call this month.

* The War Department instructions to corps area commanders (September 24) regarding the first call for reserve nurses state that nurses "engaged in essential public health activities . . . should not be encouraged to volunteer."

Public Health Practice in Scarlet Fever

By J. E. GORDON, M.D.

A discussion of the cause and clinical picture of scarlet fever, measures for limiting its spread, specific prevention, and the nurse's functions in its control

THERE IS no justification for complacency about scarlet fever because of the existing favorable situation in respect to clinical severity and mortality. Although considerable advances have been made in recent years in methods for control, much remains to be accomplished in the general field of prevention. Prevention is understood here in the broad sense to include not only measures which inhibit the development of disease, but also those which tend to decrease damage to the human host—whether that damage be physical, economic, social, or psychological. In a word, no sharp marker separates actual preventive medicine from good clinical medicine.

CHANGING CONCEPT

The changing conception of scarlet fever that has been under way the past several years has led to a much better appreciation of the relationship between this disease and other streptococcal infections. In the first place, there is almost universal agreement that the infectious agent responsible for scarlet fever belongs to the group of hemolytic streptococci. Moreover, an appreciation has gradually evolved that the disease scarlet fever is distinguished from other streptococcal infections principally by the addition of toxic manifestations to the reactions of tissue invasion that characterize all streptococcal disease.

Although long considered a specific communicable disease in the sense of cholera and plague, scarlet fever now ap-



Lee F. Redman, Detroit

Dr. J. E. Gordon of the Harvard Medical School, who is now head of a field, laboratory, and hospital unit in England for the study and treatment of communicable diseases under war-time conditions. (See page 707)

pears to be a disease syndrome, one only of the multiple manifestations of hemolytic streptococcus disease, and capable of being caused by any one of a wide variety of these microorganisms. Two individual and variable characteristics determine whether scarlet fever or simple streptococcus infection develops. One is a function of the infectious agent and manifests itself in a varying ability to generate a rash-producing toxin. The other is related to the host, and involves the presence or absence of specific resistance to that toxin. Thus, the scarlet fever syndrome follows only when a

susceptible person is invaded by a streptococcus capable of producing toxin. Such a streptococcus attacking a host immune to the toxin produces only sore throat; and that condition also follows even when the host is susceptible, providing the streptococcus is powerless to generate the rash-producing toxin.

NOT A PROBLEM OF RASHES

So interpreted, scarlet fever becomes a streptococcus problem and not a problem of rashes. In addition to patients with angina and rash, those who develop only sore throat or tonsillitis from exposure to the patients must be considered as having scarlet fever infection. Scarletinal angina without rash is theoretically just as active a source of infection as are infections with a rash—perhaps more so because the danger is not appreciated, and no isolation is imposed. If angina or sore throat are known to follow exposure to patients with scarlet fever, the condition should be treated like scarlet fever. That some instances of sporadic tonsillitis are of similar nature has likewise been demonstrated. Many and perhaps most of these are not due to toxin-producing strains commonly associated with scarlet fever. If relation to known scarlet fever cannot be established, they are to be considered as simple streptococcus sore throat. This administrative policy is necessary because of the lack of satisfactorily simple methods for determining their actual nature.

Probably no epidemic of scarlet fever infection is ever wholly composed of classical infections with a rash. Depending on the average immunity status of the community and the biologic characteristics of the particular strain of hemolytic streptococcus, varying proportions of affected persons will have classical scarlet fever, sore throat only, or an acute upper respiratory infection. An epidemic due to a streptococcus with little ability to produce toxin will likely

be of decidedly mixed clinical character, with cases of sore throat predominating and a lesser number of recognizable instances of scarlet fever. A strain that produces a strong toxin will show a preponderance of true scarlet fever.

MEASURES FOR LIMITING SPREAD

The official health agency is responsible for the administrative measures designed to limit the spread of hemolytic streptococci, but it is the sympathy and support of the private practitioners that determine the degree of practical accomplishment. By eliminating unnecessary restrictions and by avoiding regulations so strict that they are beyond ready accomplishment, health departments can expect improvement in the important matter of reporting recognized cases.

No health department, state or local, can prevent or control disease effectively without knowledge of when and under what conditions cases are occurring. The frequent epidemiological relation between infections with sore throat and rash, and others with sore throat only, becomes increasingly apparent to physicians and to public health nurses. If rash is present, the patient is subject to rigorous restrictions; in its absence he is ordinarily wholly unaffected by official regulations. This tends to discourage reporting of borderline or doubtful cases. Much better reporting has been brought about when provision is made for an administrative distinction between suspected and proven cases, the restrictions on doubtful cases being temporary and remaining so until satisfactory decision is made as to whether or not the patient has scarlet fever. More equitable and individualized regulations for isolation would also lead to an expectation of better notification. The primary obligation for reporting communicable disease rests of course with the attending physician, but in the absence of medical attendance it becomes a function of the public health nurse.

The short incubation period and the prolonged infectiousness of scarlet fever make prompt recognition of the disease an essential part of a program for control. The clinical symptoms of the usual case are so characteristic that the only difficulty comes with mild infections and those with fleeting or indefinite eruptions. When health departments provide facilities for clinical consultation, the extensive use of this service by practicing physicians is indicative of its need. Furthermore, such a diagnostic service is the natural complement to the work of the public health nurse in confirming the suspicions which her field investigations have unearthed.

THE NURSE'S FUNCTIONS

In accordance with general practice in this country, the responsibility for field visits to patients with scarlet fever is largely a function of the public health nurse, as is also the institution of proper measures for protection of immediate contacts. Prompt investigation of newly found cases is about the most important measure for limiting the spread of the infectious agent. The personal sort of instruction and help that the public health nurse brings to the family of the patient contrasts with the idea of police power so commonly, if incorrectly, associated with the sanitary inspector. Where home isolation is as generally practiced as it is in the United States, its effectiveness depends to a considerable extent on the instructions given by the visiting nurse, and on actual demonstration of the methods involved in concurrent disinfection—in the disposal of food, and in the care of dishes, garments, linen, thermometers, and instruments. If the patient is removed to a hospital, the nurse supervises the terminal cleaning, airing, and sunning of rooms, which have almost universally displaced the time-honored chemical disinfection. She also advises on the measures for protection of individual members of the family. Prom-

inent among these are isolation and quarantine.

ISOLATION AND QUARANTINE

In view of the various ambiguous and inaccurate uses to which the words *isolation* and *quarantine* are not infrequently put, an arbitrary but useful distinction is made. Isolation applies to the limitation put upon movements of the known sick or "carrier" individual or animal, while quarantine applies to the restriction of healthy persons exposed to infection.

Isolation and quarantine practice in scarlet fever makes use of blanket regulations applying to the disease rather than to the person concerned. Little consideration is given to individual differences in severity of infection or probable degree of communicability, in contrast with the efficient and individualized regulations for patients with typhoid fever and diphtheria. Although lack of suitable laboratory methods for determining persistence of the infectious agent makes this unavoidable to a certain extent, advantage can be taken of known epidemiologic information.

So marked are the differences between patients with simple and complicated scarlet fever in their ability to transmit the disease that most public health regulations prescribe longer periods of isolation for complicated cases, with a maximum that varies from two to three months. Group studies* have shown that children under five years of age are responsible for about eleven times as many secondary cases as are patients fifteen years of age or older, and that the degree of communicability evidenced by patients of all ages is less in summer than in winter. Since the requirements for isolation rest essentially on opinion and experience, considerable differences in practice exist even for simple, uncomplicated

* Gordon, J. E. "Epidemiology of Scarlet Fever." *Journal of the American Medical Association*, February 13, 1932, p.519.

cated infections. The period ranges from a maximum of six weeks to a minimum of two weeks. The longer periods often date from many years past, when scarlet fever was much more severe, and also a more common disease. Both clinical and epidemiological evidence indicates that isolation requirements can be favorably modified to conform with the prevailing behavior of the disease.

HOME VERSUS HOSPITAL CARE

The recommended place of isolation varies almost as much as the length of isolation. Improved housing conditions of the present century make it reasonable to believe that home isolation will progressively become more practicable even in cities, and that hospital isolation will be reserved for situations where the medical needs of the patient require it, or where home conditions prevent adequate isolation. In the hospital, isolation falls into routine, but at home it is an individual problem which the public health nurse must settle according to the nature of the particular house and household. The limits of the isolated area must be clearly defined, and may be the floor of a house, one room, or a part of a room. The fewer the people, the smaller the amount of furniture, and the simpler the conditions within this area, the easier it is to manage.

PUBLIC EDUCATION

Modern programs for the control of communicable disease have as their foundation adequate instruction of the public in the mechanism and nature of these diseases. Realization of this program depends first upon assuring full acquaintance of the public with the problem of scarlet fever in advance of possible difficulties; and second in providing precise factual information for limiting the progress of the infection once scarlet fever has invaded a home.

As a permanent practice in public health education, more nurses should

meet with community groups to present the problems of communicable disease, for the personal discussion of particular problems usually proves to be more valuable than the studied address of an expert.

In the presence of scarlet fever, the public health nurse can give a practical demonstration of what to do and how to do it which the physician in the face of other obligations commonly fails to accomplish satisfactorily. Since the suggested procedures are often unfamiliar and sometimes detailed, those responsible for the care of a scarlet fever patient may have difficulty in remembering her instructions. A pamphlet designed to supplement the personal recommendations of the nurse with the authoritative directions of the expert adds much to satisfactory proper understanding.

MEASURES FOR CONTACTS

Although young children are most susceptible to scarlet fever, the frequency of secondary cases among family contacts is low, compared with diseases like chickenpox and measles. If a patient with scarlet fever is isolated at home, it is desirable to remove susceptible children to the home of adult relatives or friends who have no children. When this is done, the exposed children must be kept out of school for one week, but no other restrictions are necessary except perhaps a warning card. If the patient is removed to the hospital, the children remain at home under the same conditions. Where both patient and contacts remain at home, quarantine of unaffected children under fifteen years of age must continue through the period of isolation.

What appears to be sensible administration is the developing tendency to permit greater liberty to adult family contacts, irrespective of whether the patient is isolated at home or at the hospital—provided their work does not bring them in contact with food for pub-

lic consumption, or with the care of children. For the purpose of this regulation an adult contact is defined as one who is not attending the patient, who is 15 years of age or older, and who must leave the premises for a useful purpose.

CONTROL MEASURES IN SCHOOLS

Children in secondary schools, college students, and teachers and other adults working in the secondary schools in direct contact with the children are given permits to return to school under the same conditions that govern other adult members of the household, providing they avoid caring for or associating with the patient, and do not enter the isolation area.

Children in schools or institutions who have been exposed to cases of scarlet fever should be examined carefully each day during the following week. With any indication of scarlet fever or sore throat, they should be promptly excluded until proved free from scarlet fever infection. When this method does not control the situation, Dick testing of all contacts is useful in finding those who are susceptible. The susceptible group should then be given special grouping or immunization either by injection of toxin or by one of the methods for passive protection. Schools are advisedly not closed where daily observation of children by a physician or nurse can be provided.

SPECIFIC PREVENTION

A desirable adjunct to any program of specific immunization is a method for sorting out susceptible persons from those who are immune. This is accomplished in scarlet fever by the Dick test, which experience has shown to be a reliable procedure for indicating susceptibility to classical scarlet fever.

Passive immunization is used where the need exists for prompt protection against known exposure, particularly for persons suffering from other illnesses,

from poor nutrition, or from other inadequacies of health. In general, it is limited to circumstances where repeated exposure is unlikely. With few exceptions, hemolytic streptococcus antitoxin will protect against scarlet fever for two to three weeks, but the method is seldom used because the serum reactions that commonly follow are often more serious than the prevailing type of scarlet fever, and because of the frequent and permanent sensitization to horse serum. Serum obtained from the blood of persons recently recovered from scarlet fever is of considerable value. Although individual preparations vary in efficiency, the method is extensively used in the cities of the United States where facilities for its preparation have been provided.

The method originated by the Doctors Dick for inducing active and long continued immunity has repeatedly demonstrated its worth in protecting student nurses, children in institutions, and susceptible persons in the general population against recognizable scarlet fever. The recommended program of five injections of toxin, beginning with 500 skin test doses and increasing to a final 80,000 skin test doses, results in immunity to the toxin in about 90 percent of susceptible persons, judging by a change of the Dick test reaction from positive to negative.

Two reasons account for the rather limited extent to which this method is used. First there are administrative difficulties involved in the required series of five injections, especially since the reactions that follow are rather frequent and sometimes severe. A second consideration is the doubt held by a number of authorities as to just what is accomplished in respect to community protection. If immunized persons are not protected against scarlet fever infection, but only against the toxic and eruptive features of the disease, they remain a source of infection for

true scarlet fever through passing the agent to susceptible contacts. Rather complete immunization of a community would thus be necessary if recognizable forms of scarlet fever were to be eliminated.

MANAGEMENT OF SCARLET FEVER

Although the number of people who contract scarlet fever is now about the same as it was fifty years ago, the number who die is much less. Much of the change is due to an improved level of general health conditions, but the most important factor is the existing favorable state of equilibrium between host and parasite. Also contributing to lower case fatality rates are the improved methods for specific treatment and the generally better management of those who become ill. The physician has at his disposal a choice of streptococcus antitoxin, of convalescent serum, and of immunotransfusion.

The danger from this disease lies more in what may happen in the course of convalescence than from the acute manifestations of the infection. For this reason the general medical management of scarlet fever retains all its importance. The chief responsibilities of the nurse include a continued vigilance for the onset of complications, the satisfactory maintenance of bed rest, and careful attention to the diet of the patient. Ideas about diet have changed materially in recent years. In the days when a milk regimen was the accepted dietary management of scarlet fever, nephritis was frequent. Change to a more general diet has led to much better results so that nephritis is now an uncommon complication. During the first days of scarlet fever, nourishment is commonly limited to liquids, but cooked vegetables, cereals, and fruits are promptly added, and during later convalescence the diet is guided by appetite and is more or less unrestricted.

The practice of isolating complicated cases from those whose course is limited to the ordinary manifestations is common practice in hospitals but is often omitted under home management.

Secondary infections of the upper respiratory tract are frequently the inciting factor in the development of complications. For her own good and for the protection of the patient, a nurse with a cold or other similar infection should not attend patients with scarlet fever.

SUMMARY

In the control of scarlet fever, an important function of the public health nurse is to act as intermediary between theory and practice. She has the opportunity, more than most other workers in public health, to bring into play the known facts which give promise of more adequate control. A goodly part of her accomplishment will come from example and from demonstration, but still more from the part she plays as a public health educator.

Two useful principles for guiding her activities in this disease are as follows: First is the appreciation that simple infections of the upper respiratory tract developing in association with classical scarlet fever are themselves usually scarlet fever infections, clinically different but etiologically identical; that they are potential sources of infection for true scarlet fever and are to be given equal attention with the manifest disease in whatever control measures are instituted.

Second, the period of convalescence is the really critical time in the course of scarlet fever. Secondary fevers after defervescence are indicative of developing trouble and must invariably be investigated in order that early recognition and prompt remedial measures may discount the death and disability that come from complications.

Nursing in a Great California County

By EDITH EYSTER, R.N., AND ANNAMAE MAHANEY, R.N.

On the twentieth anniversary of their director's service, Los Angeles County nurses review the growth of their program during a period of tremendous expansion in the West

THE YOUNG doctor crowded his sputtery "jalopy." In 1915, that dusty road stretched endlessly ahead. What a mountainous task confronted this newly appointed health officer! His county area covered 4000 square miles, including high mountain peaks, hot desert regions, fertile orange groves, and thriving industrial districts, and finally ended at the great Pacific Ocean. As he slammed on the brakes, the car grumbled and stopped.

Passing into his meagerly furnished office he threw himself into his chair. His problems loomed before him. There was no doubt about it: California was booming and Los Angeles County was rapidly losing all vestiges of a typical rural community. New oil and cinema industries were importing many specialized workers and artists. Low-cost labor from Mexico was being shipped in by carloads. Orientals were coming in search of vegetable farms. The semi-tropical climate was attracting both the infirm and pleasure-seekers. And some were coming because they had "heard so much about it."

This motley group must be unified and their health consciousness aroused. It was of no small concern that 100 babies out of every 1000 died each year; that epidemics of smallpox, typhoid fever, and typhus fever could not be effectively controlled; that tuberculosis took a tremendous yearly toll. This fluctuating, disorganized county must somehow be brought into a cooperating whole—and yet there were no precedents

by which to evaluate and meet the unique problems. Police methods had failed. The obstacles were too great for a health officer to surmount alone. The organized forces of sanitation and public health nursing would have to come to his aid, and complete health service must be made geographically accessible to all.

In 1916, an epidemic of typhus fever offered the opportunity for the inauguration of the public health nursing program. By using personal service as a wedge, these public health nurses were able to assist the county health officer in convincing the "city fathers" that a coordinated health program was both economical and humanitarian.

Public health nursing was further stimulated by the American Red Cross, which lent a specialized public health nurse to aid in tuberculosis control. Because this nurse helped to convince the public of the need for effective control, her work grew from the inadequate home care administered in tents to the efficient and individual care in well equipped sanatoria. Several years later, the tuberculosis program became an integrated part of a generalized service. Today, the health department has made outstanding contributions to the epidemiology of tuberculosis.

Since the nurse had to foster a wholesome community attitude, the health officer recognized that each public health nurse who was employed in this reorganized department must possess not only professional skills, but also emo-



An early health center in 1920

tional poise and ability in leadership. For the purpose of selecting and training this type of nurse, the health officer appointed a qualified nurse director. Recognizing the need for continuous staff education, she initiated a program of round-table discussions and lectures, closely resembling the methods of education used today. She instituted a schedule of conferences with individual nurses, which not only stimulated personal and professional growth, but aided in the solution of many district problems. Nurses were encouraged to attend night classes at the universities. Leaves of absence were granted for enrollment in summer courses. A well developed plan to train the new public health nurse gained recognition from public health leaders in the universities and in the state.

DECENTRALIZATION OF SERVICES

In an effort to reduce the infant mortality rates, the Health Department service was decentralized, making health facilities available to all the people in this sprawling county. Many communities were persuaded to donate the land or the buildings for the project. As these health centers became an integral part of community life, public coopera-

tion and understanding were made possible, thus paving the way for effective public education. During the same period, the independent school systems were brought into reciprocal relationship with the health department, when nurses who had been trained by the department were employed by school boards.

As the organization grew, the nursing service was correlated with the various other bureaus as they were created. Coöperating with the Bureau of Maternal and Child Hygiene, district nurses contributed to the promotion of health by teaching and demonstration in the home, and by arousing public interest in child hygiene, maternity care, and health education. There was a drop in the infant mortality rate from 100 per 1000 live births in 1917 to 27.9 per 1000 in 1940. The establishment of local subcenters, making child health conferences available to all, was largely due to efforts of district nurses.

GENERALIZED NURSING DEVELOPS

As the Bureau of Public Health Nursing expanded, the specialized services gradually gave way to a generalized program. Teaching health principles or the care of the sick in the home, the public health nurse recognized her responsibility to the family in helping them with their problems. With the advent of the medical social service program, the nurses were able to relinquish the responsibility for social problems and to concentrate on the pressing health needs. Today, the program of health conservation, particularly through control of communicable diseases and promotion of maternal and child health, forms the greater part of the day's activities. Through the years, the nurses working in clinics and in the field have endeavored to reduce the incidence of syphilis and gonorrhea. At the present time, an educational program is being re-emphasized and is enthusiastically received.



The East Los Angeles Health Center today

DEMOCRATIC LEADERSHIP EFFECTIVE

The staff nurses of the Los Angeles County Health Department believe that the outstanding feature in their nursing service is its growth through democratic supervision throughout its entire period of development. Practically all of the policies of the nursing group have been determined by representative committees. Group participation in planning and organizing nursing techniques and procedures affecting all services is encouraged by the appointment of committees of nurses.

The Record Committee, comprised of five members from the supervisory group, has the function of preparing, improving, and standardizing records, subject to the approval of the health officer. Staff nurses who use these records contribute to the committee's work by voicing their suggestions in the informal district meetings.

The Nursing Procedures Committee consists of the supervisory group with staff representatives. Techniques and procedures used in the clinic and field have been developed and incorporated into manuals. This group is now preparing a manual for the use of the staff nurses who are responsible for the teaching of affiliating students from the schools of nursing.

The Public Health Nursing and Med-

ical Social Service Coördinating Committee was formed to clarify working relationships. At the request of the National Committee for Teaching Student Nurses of the American Association of Medical Social Workers, joint case studies to illustrate day-by-day activities were prepared for use in working with students.

Monthly supervisory nurses' meetings are conducted by the informal conference method. Local problems are freely discussed and solutions suggested from the experience of the group. There is always an "open door" for individual conferences with the nurse director, who is a member *ex officio* and attends all committee meetings.

STAFF EDUCATION PLANNED JOINTLY

A committee of staff representatives from each of the districts, with the educational director acting as chairman, make plans for the staff educational programs annually. Subjects for discussion or lecture proposed by this committee are approved by popular vote. Two years ago, a series of conferences on teaching techniques was held by the State Department of Education. The leader, who was skilled in the conference method, helped the staff to analyze objectively the problems in the public health nursing program. Each nurse was given

an opportunity to present a difficult situation, and the reasons for success or failure in each case were analyzed in small group conferences. This stimulation to further thinking and action bore fruit in subsequent district staff meetings. Here, problematic phases of daily work—such as the effective application of teaching skills in helping to meet the problems of the tuberculous patient, or methods of recording home visits completely and concisely—were subjected to careful scrutiny.

In response to suggestions of staff members for improving the method of introducing new members to the organization, several staff nurses were selected to serve as staff supervisors in the orientation of new nurses. Through the preparation and use of a teaching manual, these nurses were able more effectively to guide and stimulate the new staff during their two months' orientation period. This experience opened up new avenues of professional growth for these staff advisers.

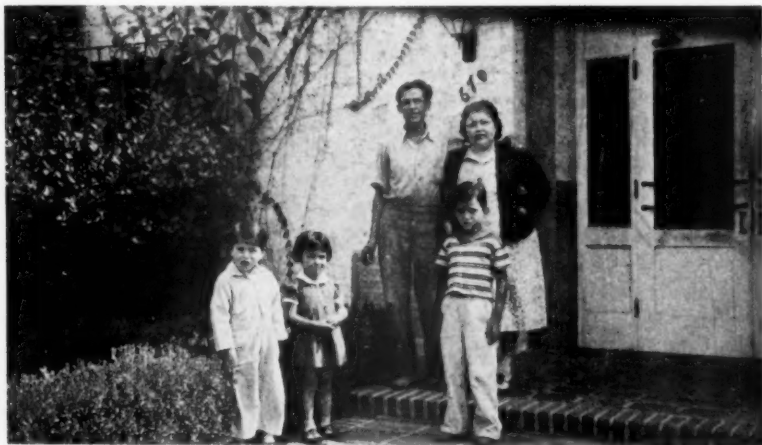
As a result of our democratic form of leadership throughout the years, the entire staff shares an exceptional enthusiasm, and devotion to service. Although in 1930 the budget was greatly decreased and the number of public health nurses

reduced, while the health problems and case load increased, the last decade has been one of professional growth for the organization and for its members.

Teaching and demonstrations to groups at the health centers have helped to meet the increased load. Prospective mothers show much interest in the weekly classes, where blackboard illustrations and table displays are used by the public health nurse in presentation of her material. One district has a class for prospective fathers. Group teaching of parents in child health conferences is one of the fairly new projects.

Another method of group teaching applied to both professional and lay groups is a series of playlets illustrating home calls to antepartum, tuberculous, diphtheria, and luetic patients. These are presented by the staff to new members, student affiliates, and lay and professional organizations.

By these and similar methods, each member is stimulated to make her contribution to the nursing program. New ideas are welcomed. Old ideas are not revered unless they are more effective, and nurses need not be afraid to challenge them. Thus Los Angeles County nurses point with pride to twenty years of successful democratic leadership.



A young Mexican family learn healthful living at the Center

AT AN August birthday party for Lillian Simpson, director of the Bureau of Public Health Nursing of Los Angeles County Department of Health, the public health nurses of the organization expressed their sincere appreciation and love for their director. They paid tribute to Miss Simpson, not only as an inspired democratic leader, but also as a friend to each of her nursing staff as well. In November, the entire Health Department staff will present Miss Simpson with a gold service button in recognition of her twentieth anniversary of loyal service in the Department.



Lillian Simpson

A New Milestone in Standards

Agency membership in the National Organization for Public Health Nursing

IN 1912 at the organization meeting of the National Organization for Public Health Nursing in Chicago there was established, along with other forms of membership, a corporate or agency membership of ten dollars a year. The enacting clause of the first bylaws reads:

Article IV—Corporate Members

Any organization engaged in public health nursing, whether a private society, a church, a business enterprise, a city or state board or committee, or any governmental body, shall be eligible for corporate membership provided that they conform to the minimum requirements for membership as established from time to time by the association, shall be entitled to one vote cast by a delegate in attendance, who shall be a nurse and a member of the American Nurses' Association.

Shortly after this first meeting in Chicago, standards of membership of various types began to be defined; and a requirement for agency membership was added, stating that agencies in order to be eligible for membership in the N.O.P.H.N. must show that 75 percent of the employed nursing staff were eligi-

ble for individual nurse membership. Later this was changed to 80 percent.

In 1936 this eligibility clause was withdrawn altogether because of the difficulty in keeping N.O.P.H.N. records up to date and checking on each nurse's qualifications in each agency every year, and because in most agencies the standard meant very little and was not used in any particularly constructive way—though without doubt the requirement had benefits for the small agency attempting to raise its standards for staff nurses. From 1936 to the present time, the payment of dues has been the only requirement for agency members.

Through these years, however, the thought of more definite standards for agency membership has persisted. There has been frequent discussion in board, committee, and staff meetings. The membership voted a differentiation among agencies by establishing a five dollar yearly membership known as an "associate agency" membership for agencies not directly administering public health nursing but interested in it. This still exists.

It was found that in the social work

field an agency membership represented a very live, real national standard which must be met. It became a little embarrassing for the N.O.P.H.N. when representatives from other national groups would say "Of course the Blanktown Public Health Nursing Service is good, because it is an agency member of the National Organization." Was it good, or wasn't it? Frequently a young nurse seeking a position, or a student seeking affiliation, or a board member looking for an employee would ask for our "rating" of such and such an agency.

By and large there have been great strides in other public health nursing standards in the last twenty years. We can point with pride to 26 approved programs of study in public health nursing in colleges and universities. We can point to more than half of the public health nurses in the field who are meeting the ever rising standards of N.O.P.H.N. membership and a good percentage who are meeting the even higher requirements for appointment to positions.

Standardization among member agencies has been implied for a long time. The N.O.P.H.N. Ways and Means Committee, writing in 1919, said: "Corporate membership is a very vital thing, as it represents the standardization of public health nursing throughout the country, and is a guarantee to the people that not only are the nurses in public health work adequately prepared, but that their work is thorough." In 1920 there were 115 agencies admitted as "meeting our standards."

Yet until this year, 1940, any agency sending dues has been recognized by the National Organization as a member agency in good standing. Recently we have come to feel that standards for agency membership should be established as actual realities that stand for something. We see in them a means of securing a better organization for public health nursing work, better representa-

tion of lay groups, better service to the community from qualified nurses.

The results of all this thinking you know: the acceptance by the Board of Directors in January and by the membership in May 1940 of the first definite set of standards for agency membership in the N.O.P.H.N.

Today the bylaws covering agency membership in the N.O.P.H.N. read:

Article I, Class B—Agency

Agency members shall be those organizations or other groups administratively engaged in public health nursing. Applicants for agency membership shall submit applications to the secretary to be referred to the Eligibility Committee. After approval by the Eligibility Committee the applicant shall become a member upon payment of dues as hereinafter provided.

Every group, official or nonofficial, administering public health nursing services in the United States and its possessions, will be sent upon request a copy of the standards, with an application blank for agency membership in the Organization. Our first list of member agencies meeting these standards will be published and available to all in 1941.

WILL BE OF VALUE TO ALL

This step should have a meaning to every one of us. To the citizen it will be an assurance that as a taxpayer or contributor his support is going toward a good public health nursing service. To the community chest it should mean that like other constituent members of national agencies the local public health nursing agency meets the national standard. To board and committee members it should bring pride in accomplishment, and a renewed desire to retain national recognition with rising standards. To the nurse administrator it will offer opportunity to secure the essentials of good public health nursing service. And to all the staff—executive, supervisor, or field nurse—there should come the satisfaction of knowing that as agency

members the special services of the National and the privileges of agency members are theirs, and that through their efforts their agency takes its place in an approved group of recognized standing. For the nurse seeking a new position one of her first questions may well be: Is this agency a member of the N.O.P.H.N.?

The National has for several years planned special services just for agency members.* We expect to develop more of these as we come to know you better through this closer relationship based on approved membership.

"And what if we cannot qualify?" Already this cry has come to us in worried tones. These first standards are very minimum and uncomplicated. Like the first standards of nurse-membership in the N.O.P.H.N., they set goals within the reach of nearly all agencies. Those unable to meet them now should be able

to do so within a few years. The National will help you to meet them in every way possible. Its Eligibility Committee has a genuine understanding of the difficulties and delays in revising bylaws, electing officers, securing medical advisory service, setting up new record systems, or revamping staff procedures. Furthermore, the membership eligibility secretary herself will visit you if you wish. *We want you to qualify.*

It is the earnest hope of the N.O.P.H.N. Board that the first published list of agency members will include at least 50 percent of all those administering public health nursing in the United States.**

DOROTHY DEMING, R.N.
*General Director, National Organization
for Public Health Nursing*

*For a summary of these see "Annual Report to Member Agencies" for 1938 and 1939.

**A future editorial will give a description of the privileges of agency membership.

N.O.P.H.N. DINNER HONORS ITS PRESIDENT

RED DAHLIAS, gleaming silver and glass, and American flags formed the setting of the N.O.P.H.N. dinner attended by more than 600 public health nurses and laymen in gala attire at the American Public Health Association convention in Detroit on October 7. The dinner honored Grace Ross in tribute to her 25 years of service in the Detroit Department of Health. It was a fortunate coincidence, as Marion Howell, toastmistress, pointed out, that Miss Ross should be serving as president of the National Organization for Public Health Nursing, completing 25 years of service in Detroit, and playing hostess to the A.P.H.A. convention all at the same time. Dr. Henry F. Vaughan, health commissioner of the City Department of Health, presented to Miss Ross a life membership in the American Public Health Association as a

token of appreciation from the Department. And the nursing staff, acting on Miss Ross' own suggestion, turned in 133 lay memberships in the N.O.P.H.N. for 1941. The nurses' glee club sang three selections, the last one just for Miss Ross herself.

Miss Ross' response to all of this was characteristic. She turned the tables adroitly by thanking everyone who had made the progress in the Department possible. By the time she had finished, the unwary listener had almost forgotten whose anniversary was being celebrated!

These ceremonies were followed by an address, "The Citizen Looks at Public Health," by Margaret Culkin Banning, after which Miss Howell brought a memorable occasion to a close with greetings to Miss Ross from the board and staff of the National Organization.

Endemic Typhus Fever

By R. E. DYER, M.D.

Endemic typhus fever—commonly known as Brill's disease—is present in the southern part of the United States, transmitted to man from the rat

ENDEMIC TYPHUS fever in the United States was first reported in the South at Atlanta, Georgia, in 1913. Other reports followed in the next few years—from Charlotte, North Carolina, in 1914; Galveston, Texas, in 1916; and others. In 1923 a number of cases were reported in Alabama. These cases were identified as being immunologically and serologically identical with classical typhus. The epidemiological features indicating the rat as a reservoir are too well known to need any discussion here.

It may be said that since Maxcy's first epidemiological study in 1926¹ no facts have been brought to light in subsequent studies in our southern states which bring into question the transfer of typhus from a rodent reservoir to man by the rat flea—probably through the medium of the flea feces rather than through the bite of this insect.

In 1929 the human cases of endemic or murine typhus were practically limited to the towns, particularly those along the southern Atlantic coast from Baltimore south and continuing along the Gulf Coast and up the Rio Grande as far as El Paso, with a few cases in Southern California. Towns in the interior of the southern states were likewise affected but to a lesser extent as the distance from the seaboard increased. As late as 1932 the northern limit of the disease in Alabama was about in a line with Montgomery. Since 1932, cases have ap-

peared farther north, until at present the northern border has reached central Tennessee.

DISEASE SPREADS TO RURAL AREAS

Coincident with this geographical extension of typhus there has been an extension to the rural districts. This was first noted in Alabama and Georgia in the so-called peanut belt and has more recently been noted in Texas. In Alabama it is estimated that 30 percent of the typhus cases occur in strictly rural areas. Hendrick² makes the statement that 84 percent of the cases in Worth County, Georgia, are rural. Texas also shows a spread of the disease from the towns to the country in certain sections.

Various suggestions have been advanced to account for the loss of the strictly urban character of our endemic typhus. Foremost among those is the part played by the increasing acreage planted in food crops in the southern states in recent years. This has resulted in the storage of foodstuffs on the farms, which was practiced in relatively small degree prior to 1929. This storage of food on farms earlier given over to the cultivation of cotton presumably has tempted the rats from the towns and cities. It is very difficult to get any reliable data on such migrations. Oldsters among the farmers of the affected sections, although claiming a long acquaintance with native wood rats, state that the wharf rat is a recent arrival on their farms. Just how much weight can be

given to such evidence it is hard to say. However, an infiltration of the rural areas by rats from typhus foci in towns would amply explain the spread of typhus to the country.

One other factor probably explains some of the rural cases and surely plays a part in keeping the disease alive in nature, namely, the proven presence of the infection in a species of native field mouse which is rather widely distributed along the Gulf coast. The most important rodent reservoir, and surely the first observed, is the gray rat. Apparently the infection has spread to one species of field mouse, and other species of rodents may already be infected, since it has been shown that several native species are experimentally infectible.

PREVALENCE OF THE DISEASE

How long this disease has been present in this country it is impossible to say. It surely was present many years before it was recognized. It is also true that beginning with 1923, physicians have become more and more conscious of typhus. This has naturally resulted in a wider recognition of cases, which must be taken into account in following the prevalence of the disease during the years. In 1925, about 150 cases were recognized and reported for the United States. This number increased slowly each year until 1929, when 250 cases were reported. The number doubled the next year, but receded to 350 in 1931. Two years later the reported cases numbered 1922. This was followed by a two-years' decrease, the number in 1935 being 1195. This decrease in cases followed extensive rat poisoning campaigns in Georgia, Alabama, and Texas, the three states reporting the greatest incidence of typhus. Since this poisoning of rats was carried out over wide areas and no control area was set up, it was not clear that the decrease in the number of reported cases during 1934

and 1935 was the direct result of the destruction of rats. However that may be, it does give an indication that the rapid increase in reported cases during the two preceding years could not be entirely explained on the basis of increased recognition.

From the available figures there is little noteworthy change in the age and sex incidence. All ages are affected, with the greatest incidence in the years 11 to 39, this period accounting for over half the cases.

Males are more often attacked than females. Kemp³ gives the figures in Texas as approximately four males to one female. Farther east the ratio is about two to one. This, as well as the age distribution, is to be expected, since male workers in the store and on the farm are more exposed to contact with rats than are housewives and children.

In general, these features of typhus are the same as those described by Maxcy in 1926. Only in one particular is there noteworthy variation from his reports. He failed to find cases in Negroes. This may have been due to the comparatively small number of cases reported in the years of his study; or cases among Negroes may be, in fact, a development of the past few years. Beginning with 1932 the colored race has furnished a little under 10 percent of the reported cases. The rate of increase in this race has been somewhat more rapid than in the white race, but the discrepancy is not wide enough to warrant comment.

CLINICAL PICTURE

In a few cases in which the incubation period in endemic typhus could be determined with some degree of accuracy it varied from six to fourteen days. The onset may be preceded by poorly defined prodromal symptoms for a few days, but in the majority of cases the disease begins suddenly with a chill, or repeated chills or chilliness, fever, headache, and

prostration. The appetite is lost, and constipation is the rule.

The fever rises steadily, each day's maximum exceeding that of the previous day, the highest point being reached in from three to six days. Morning remissions of from 1° to 3° F. occur. The fever terminates usually by rapid lysis about the end of the second week, most often on the fourteenth day, the great majority being afebrile by the sixteenth day.

The eruption most often appears on the fifth day, occasionally being noted as late as the seventh. It appears first on the inside of the upper arms, or sides of the chest, and on the upper abdomen. No extension of the rash from this location may be noted in some of the cases. In one patient a total of seven macules was noted, while a second case at no time presented more than a dozen and a half lesions. In more pronounced cases the development of the rash is rapid during the first 24 hours after its appearance. In cases showing a well marked rash the eruption is also present on the shoulders and over the back, and may extend down the forearm, usually leaving the wrists and hands free. Occasionally in severe cases the rash may involve the thighs and the palms. The rash usually stops at the knees, although occasionally the lower legs, feet, and soles may be affected. The face and neck are seldom involved. Rash in the mild cases may persist only two or three days and in the majority of cases disappears by the time the temperature reaches normal. In rare cases the rash may persist as discolorations for a week or ten days after defervescence. These discolorations may be especially noticeable after taking a warm bath.

The eruption consists of macules rose-red in color and two to three mm. in diameter, with rather poorly defined margins. The lesions fade on pressure but may not completely disappear. In the severe cases the individual macules

become petechial (well marked) fairly early. Occasionally some of the lesions may be maculopapular, and occasional cases have been described in which no rash was observed during illness.

The pulse is apt to be slow, seldom exceeding 100, even with a high temperature. During early convalescence the pulse may remain below sixty for several days. This slow pulse may be supplanted by a rate higher than normal for a few weeks after moderate activity is resumed. After severe attacks shortness of breath after moderate exertion may be present for a few weeks, suggesting a myocardium weakened by toxemia.

Headache is almost always present from the beginning. It may involve the whole head but is more commonly frontal and is quite often intense, lasting throughout the illness. In other cases headache may never be distressing, being present only a few days. It is occasionally absent throughout the disease.

Some degree of mental disturbance is common. This may vary from vivid and not easily forgotten dreams to mild delirium in rare instances. Confusion and disorientation are more apt to be present at night. Lethargy, restlessness, insomnia, and irritability may be noted. Tremors, and in severe cases, twitching may occur.

Generalized aching is often present. Some evidence of respiratory inflammation is common, often showing as a mild unproductive cough. Prostration may be present from the onset and in severe cases becomes quite marked during the second week. Constipation is usually present throughout the course of the disease. Photophobia and soreness of the eye muscles may occur. Slight chills followed by sweats are not uncommon at night.

Complications are rare and convalescence in mild cases is speedy. Following the more severe cases normal strength may be regained slowly. In any

event, recovery is complete. The case fatality is estimated at less than two or three percent, practically all the deaths occurring in patients over 50 years of age.

TREATMENT

There is no specific treatment of proven value for endemic typhus and in the great majority of cases none is needed. Rest, quiet, good nursing, with relief of particular symptoms such as headache, constipation, and mental disturbance when needed are sufficient. Elderly patients with preexisting heart or kidney conditions should occasion a guarded prognosis.

PREVENTION

The control of flea-borne typhus is based on the control of the rat population alone since there is no evidence that

fleas transmit the disease from man to man.

The control of rats consists of the protection of food supplies from access of rats, and the breaking up of rat harbors. The measures employed in general are the storage of food in ratproof containers or ratproof buildings, the rat-proofing of buildings to prevent rat haborage, and the proper disposal of garbage.

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² Hendrick, A. G. Personal communication.

³ Kemp, A. A. "Endemic Typhus Fever in Texas; Epidemiological and Clinical Comparison with Forms of Typhus Seen Elsewhere." *American Journal of Tropical Medicine*, March 1939, p. 109.

THE RED CROSS GIVES WAR RELIEF

AMERICAN RED CROSS relief activities in Europe have at sometime during the past year affected all of the following countries: Finland, Latvia, Lithuania, the Government General of Poland, Rumania, Hungary, Yugoslavia, Norway, Holland, Belgium, Luxemburg, France, and England. In addition, the American Red Cross has supplied funds to its Swedish sister society to help care for Norwegian refugees, and has furnished funds to the Canadian Red Cross to assist in the construction of a hospital in England.

Besides food and clothing, Red Cross war relief shipments to Europe have included great quantities of drugs, surgical instruments, and hospital supplies. Concrete testimony that lives are being saved because of Red Cross activity is contained in the following cable received

at National Headquarters, on August 23, from a representative in unoccupied France:

Insulin from our existing supply here is filling an urgent need. Emergency requests being met immediately and many reports of lives being saved. We are working out a plan in coöperation with health authorities to meet all needs in unoccupied France for a period of from two to three months, when our stocks will be exhausted. Also government agencies on our request are making a survey of existing supplies and sources. Situation well in hand. Will give you estimates for needs soon.

Plans have been made for the shipment of additional drugs, clothing material, and other relief supplies to China for the victims of war there.

All Red Cross war relief activities are financed from the special fund raised last summer. Normal services at home are supported from annual membership dues.

Teachers Study the Child's Health Needs

By JEAN V. LATIMER

The trend in schools today is a health education program based on the child's needs, planned with the coöperation of all those interested in the children

CLASSROOM teachers today show an increasing interest in studying the physical and emotional aspects of each child, as well as knowing about the child's mental development. In order to assist in the development of a dynamic program in health education, the Division of Child Hygiene of the Massachusetts Department of Public Health is trying out experimentally a teacher's guide or plan book for use in the elementary schools.

In recognition that the basis for such a program should be the child's health needs, it is suggested that the following sources of information for the study of individual children be utilized:

1. Findings of the school health examinations.
2. Findings of the school dental examinations.
3. Continuous teacher observation of the general appearance of the pupil in terms of possible physical defects or illness, and the use of general cumulative inventory sheets by the teacher to record information about the children and their environment.
4. Individual conferences of the teacher with the school nurse, school principal, and parent.
5. Health habit surveys.
6. Health knowledge tests.

The elementary school teacher is no longer content merely with having the statistical summary of the findings of the physical and dental examinations of her children. The individual or case approach is becoming a fundamental basis for teacher guidance. An increasing number of teachers are using a summary form for findings of the school health examination which provides a

space beside each name for comments by the teacher concerning individual improvement.

Although the busy teacher as a rule does not like to keep records, recently a teacher was found who had made out a large classroom health record with the following headings:

Fifth grade health progress report for 1938-1939

Name of child	Health problem	Steps taken	Final results on progress
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WORKING TOGETHER

More attention is being given to the conferences between the teacher and the school nurse. "Well, here's the school nurse," said one teacher recently when the nurse arrived, "I certainly am glad to see her. We have to discuss what to do with Tom Burke. Last fall it was found in the school physical examination that he needed glasses. His parents had some fitted for him—but either he does not want to wear them or the glasses are not right for him. He simply will not keep them on during the school day"

At this conference the nurse suggested that the school principal write a letter to the boy's mother asking her to call at the school office to discuss the matter with the principal, the school nurse, and the classroom teacher. The mother visited the school for a conference. As a result, a further eye examination was made and a serious eye defect which had not been discovered in the previous examination was found.

This is an illustration of real coöperation between all the people concerned with the welfare of the child and of the growing importance of the elementary school principal as an administrator in matters of health education as well as

in all other phases of the child's school life.

The school nurses say that such conferences are effective not only in lessening the load of home calls but in making the school efforts dovetail with those of the home.

HEALTH TEACHING BASED ON NEEDS

Many facts about the child's physical condition, practices, and attitudes towards health may be used as bases for health unit teaching. For example, in a university extension class one of the teachers prepared a teaching unit on posture. She started out with the "needs for teaching this unit" and listed especially the various children in her classroom whose physical examination showed posture and foot defects. As the unit developed she kept these children particularly in mind.

This same teacher believed that the developmental needs of all the group should be another important basis for teaching. For example: "Children's growth throughout the year makes necessary the readjustment of seats and desks."

This tendency for the actual health problems and needs of the children to be considered in building health curricula reflects the modern method of teaching through actual problems and life situations.

For example, as an approach to some experimental teaching units in nutrition developed for the middle grades in coöperation with the public health nurse, a survey was made of the dietary habits of the children. As a part of this study the following questionnaire was given to each child.

1. Write down what you had for breakfast and how much you ate.
2. What did you eat for the noon meal and how much? At home or at school?
3. What did you have to eat for the evening meal yesterday and how much?
4. What did you eat between meals yesterday?

Although we did not consider this information to be entirely accurate it did show a cross section of the food practices of the child which were of considerable value as a basis for teaching.

FAMILY PARTICIPATION

An elementary school principal reported that such findings, pictorially presented by means of colored graphs, showed the teachers and the parents what were the actual practices of the children and where there were deficiencies. "My teachers never would believe before that the average child in their classrooms was not getting enough milk until this survey was presented," he said. "As a result of the teaching which took place following the survey, the consumption of milk by the children was considerably raised."

One elementary school principal who had the support of her community made a study, in coöperation with parents, of the health habits of the child at home. Not one parent objected. They were grateful that the school was concerned with teaching "the whole child."

Especially in the elementary schools, there is need for strengthening the relationship between school, home, and community. Teachers feel this need and they are seeking to develop means for doing their share in the community program for health. This was recently demonstrated in the selection of problems for investigation by summer session students in the health education courses offered at the Massachusetts state teachers colleges by the Division of Child Hygiene in coöperation with the Department of Education. A large number chose to study methods for coördinating the school, home, and community program in health education. The need for a more intimate type of parent education both for individuals and for small groups was recognized.

One school principal suggested the formation in each school of groups for

parent education; for example, a group of mothers of children in the primary grades and another in the intermediate grades. Such mothers would serve as an advisory group and would be called together in the fall for a conference with the school nurse and teacher. Together they would work out the health objectives of the year for each grade and the problems on which the parents would like help in guiding their children. This principal suggested that when a special health teaching unit was emphasized in a particular grade, pamphlet materials on the topic be taken home by the children for their parents.

In a section of the state where nutrition teaching has been emphasized in the middle grades, the parent-teacher organization of each school undertook the development of community groups for studying foods and nutrition. They asked the assistance of a nutritionist from the State Department of Public Health who was at the same time working with the local teachers.

INDIVIDUAL DIFFERENCES

There is a growing tendency to recognize individual differences in the keeping of health habit records. Whereas for-

merly we often found one group of children competing with another group in the same room, more emphasis is now placed on individual health achievement records. For example, recently a fourth grade teacher displayed the health work books of children in her classroom. There were individual weight charts for each child. Mary's record on "How I am growing" was different from Sally's, but both records showed relative improvement.

Also, "My individual record for a healthy mouth" is now being used more extensively than the group dental certificate plan.

Children's questions and informal health discussions are also proving valuable sources of information for teacher guidance. And objective health knowledge tests are more frequently used.

Thus, the individualization of the health program reflects the growing conviction that health education is not just telling children facts. Rather, it consists of understanding child nature and guiding children to desire improvements in health behavior. In such a program the teacher and the public health nurse are active co-partners for the welfare of the child.

A GUIDE TO THE SCHOOL NURSE

The changing concept of scarlet fever and measures for its control are of particular interest to the school nurse. Page 651.

Teachers play an increasingly important part in the school health program. Page 668.

The school child's dental habits begin in the preschool period. Page 671.

Children with congenital heart disease who attend school are the school nurse's responsibility. Page 675.

College nurses are beginning to discuss their problems together. Page 692.

Education on nutrition in schools and home must take into account the food habits of various racial and national groups. Page 682.

Dental Care for the Preschool Child

By LON W. MORREY, D.D.S.



MANY PARENTS do not realize the importance of caring for the child's teeth during the preschool period. This is unfortunate, because in relation to growth and development the deciduous teeth are just as important to the young child as the permanent teeth are to the older child and the adult.

Every baby tooth should be kept in place and free from decay until it is replaced by its permanent successor, for the following reasons:

1. The unimpaired use of the deciduous teeth aids in the development of the child's jaws.

2. The deciduous teeth act as pathfinders for the permanent teeth that succeed them.

3. The early loss of one or more of the deciduous teeth may cause some of the permanent teeth to come in crooked.

4. Healthy deciduous teeth are a mental and physical comfort to the child.

5. Decayed and abscessed deciduous teeth cause the child unnecessary pain and discomfort.

6. Bacteria from abscessed teeth or the poisons which they produce may enter the blood stream and seriously injure some other part of the child's body, such as the heart, kidneys, or joints.

The reasons for care of the deciduous teeth and important points in conservation of the preschool child's teeth are discussed in the third article of this series

7. The individual depends upon the deciduous teeth for mastication during 20 percent of the average life span.

As has been stated previously in this series of articles, the child has 20 teeth in his first, or deciduous, set, 10 in the upper jaw and 10 in the lower. No hard and fast rule can be laid down regarding the eruption of deciduous teeth. Some children naturally are slower in cutting their teeth than are others, although the normal, properly fed child will usually have his full set of 20 deciduous teeth by the time he is two or two and a half years old.

After all, the time of eruption of the deciduous teeth is not so important as maintenance of these teeth in a healthy condition until they are replaced by the

permanent teeth. Consequently, it is advisable to know what the normal life expectancy of the deciduous teeth is. The accompanying table, which is based upon computations by Kronfeld and Schour, shows the approximate ages at which exfoliation or loss of the deciduous teeth takes place.

Age, in years, at which deciduous teeth are normally exfoliated*

Upper	Central incisor	7¼
	Lateral incisor	9
	Cuspid	11½
	First molar	10¼
	Second molar	10½
Lower	Central incisor	7
	Lateral incisor	8
	Cuspid	11
	First molar	9¾
	Second molar	10½

The beginning of resorption is rather variable and is dependent on the anatomic relationship of successional teeth. Exfoliation, therefore, is also rather variable, the deviation from the average being as high as six months.

CAUSE OF DENTAL CARIES

The actual cause of dental caries is as yet unknown. Most of the research on this subject seems to indicate that destruction of the enamel and the dentin is caused by the action of a particular type of bacterium which has the ability to ferment sugar and other carbohydrate foods and convert them into acids. These acids in turn attack those surfaces of the teeth with which they come in contact. Decay always begins on the external surface of a tooth; it never arises from within the tooth.

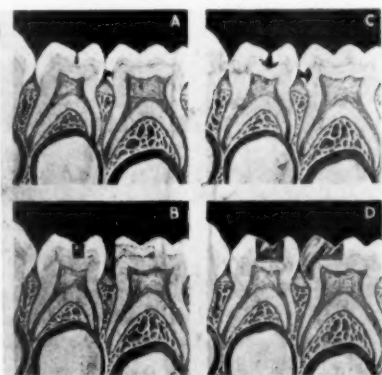
Frequently the enamel covering of the teeth is malformed, as explained by Dr. William R. Davis in "What Is the Truth About Teeth?" (September 1940 issue). Food becomes packed in the minute

flaws or enamel cracks, and even though the teeth are brushed as thoroughly as possible, small particles of food may remain between them and decay. The presence of the decayed food becomes a factor in decay of the teeth. Eventually, the dental decay will break through the enamel into the softer dentin, which makes up the body of the tooth. After the decay reaches the dentin, it travels very rapidly toward the pulp, or "nerve," and destroys it. When the pulp dies, an abscess may form at the end of the tooth root. Bacteria from the abscess may injure the child's health.

It is most important that decay be prevented from reaching the pulp of the tooth. This can best be accomplished by keeping the enamel covering of the tooth clean, healthy, and free from flaws or defects.

THE FIRST VISIT TO THE DENTIST

One of the surest measures for preserving the preschool child's teeth is to take him to the dentist when he is two and a half or three years of age. If there are any flaws in the enamel covering the deciduous teeth, the dentist can correct them easily, painlessly, and inexpensively. Once caries has penetrated



These drawings show the lower deciduous molar teeth. The small cavities in A can easily be corrected by small fillings, as in B. If neglected, the cavities grow larger, as in C, and require larger and more expensive fillings, as in D.

*Kronfeld, Rudolf, and Schour, Isaac. "Neonatal Dental Hypoplasia." *Journal of the American Dental Association*, January 1939, p. 18.

the enamel, deciduous teeth, because of the nature of the dentin, decay very rapidly. Consequently, it is advisable for every preschool child to have his teeth inspected and cared for at least every six months.

Usually, the three-year-old child has so little wrong with his teeth that most dental operations can be performed painlessly. It is logical to take the child to the dentist early, before long, discomfiting operations become necessary. This will help to prevent fear of the dental office and future dental operations and thus will enable the dentist to make friends with the child.

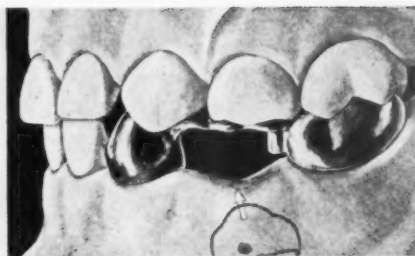
One of the parents should accompany the child to the office so that the dentist and parent can plan the child's dental program until such time as he is capable of planning for himself. The dentist can instruct both the parent and the child regarding diet and the home care of the mouth.

The dentist will examine the child's teeth and remove any stains or spots. He will correct any small defects that may be present by removing the decay and inserting a small permanent filling. It is advisable for him to take x-ray pictures of the teeth to make sure that no decayed spots on the tooth surfaces have been overlooked.

Sometimes one or more of the baby teeth become so badly decayed that they must be extracted. When this occurs, the dentist can insert a space maintainer to prevent the other teeth from drifting out of line, and thus help to preserve the natural shape of the jaws.

DENTIST IS THE CHILD'S FRIEND

Older members of the family should never plant the idea of fear in the child's mind. Dental, medical, or surgical operations should not be discussed in the presence of the child. He should be taught that the dentist is his friend. Then, when he needs the services of the dentist, he will accept them without



If a baby tooth is prematurely lost, it may be advisable to insert a space maintainer to prevent the other teeth from drifting out of line and to preserve the space for the succeeding permanent tooth.

apprehension. The child who is given this type of preventive dental care during his preschool years seldom develops the profound fear of the dental office which is common among dentally neglected children.

Usually, when the child is about five years old, spaces will appear between the front teeth, caused by the jaws growing longer and wider. The greater the spaces between the baby teeth, the more room there will be for the larger, permanent teeth that succeed them.

WHEN SHOULD BRUSHING BEGIN?

The preschool child should be taught very early in life the habit of keeping the teeth clean. When he is about eighteen to twenty months old the parent should begin to clean his teeth twice a day with a small, soft toothbrush. The four- or five-year-old child can be taught to brush his own teeth, but the brushing should always be supervised by an older person, who inspects the teeth afterward to be sure that they are clean. Children should use a small-sized tooth brush. The bristles of most modern brushes are set in tufts. The head of a preschool child's tooth brush should be five or six tufts in length and two tufts in width, with the tufts set far enough apart so that the bristles can easily be cleaned. The tooth paste or powder should contain no harsh grit or strong medicine, which might injure the

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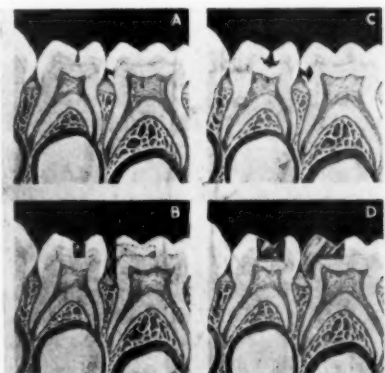
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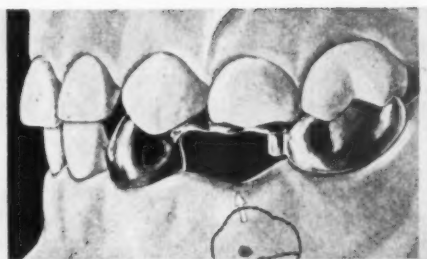
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enamel or gums.* Ordinary baking soda makes an inexpensive and effective dentifrice. The teeth should be cleaned at least twice a day, in the morning and in the evening before going to bed.

The dentist can demonstrate the tooth-brushing method best suited to the individual mouth. A simple technique often advocated for children is as follows: The jaws are held slightly apart and the teeth of each jaw are brushed separately. The bristles of the brush are placed on the gums above the upper teeth and brought down from the gums to the chewing surface. This downward movement brushes the food from between the teeth, and massages the gums. The teeth should never be brushed crosswise as this will not clean them thoroughly and it may injure the gums. The lower teeth are cleaned in the same way as the upper teeth. The bristles are placed on the gums below the teeth and drawn upward to the chewing surface. The inside surfaces next to the tongue and the chewing surfaces, as well as the outside surfaces, should be brushed. After the teeth are brushed, the mouth is rinsed by forcing

a mouthful of water between the teeth several times.

Sometimes, in spite of the most careful brushing, green and brown stain will appear on the children's teeth. These stains should be removed by a dentist because they are unsightly and they may cause decay.

As soon as the first permanent molars erupt, usually between the fifth and seventh year, they should be examined by the dentist. If their enamel covering is defective, the dentist can correct the defect before serious damage occurs.

The exact role that diet plays in the prevention and control of dental caries is not known. The use of protective foods and the probable relation of sweets to caries were discussed in the previous article in this series ("How Early Should Dental Care Begin?" by Dr. Emory W. Morris, October 1940 issue). Most dental authorities agree that the diet during the tooth-forming period should include a sufficient amount of foods containing calcium and phosphorus, plus an adequate amount of vitamins A, C, and D.

*A list of accepted dentifrices will be sent upon request to the Council on Dental Therapeutics, American Dental Association, 212 East Superior Street, Chicago, Illinois.

EDITOR'S NOTE: This is the third in a series of articles contributed by the Dental Health Education Committee of the American Dental Association.

BOTULISM

Botulism, a deadly though comparatively rare type of food poisoning in this country, is the result principally of faulty or insanitary methods used in home canning. It is caused by a spore-bearing, anaerobic organism, *Clostridium*. According to the U. S. Public Health Service, if housewives would observe the following two simple rules, the danger of botulism would be diminished:

1. Suspect and destroy all cans of home-preserved foods whose ends are

bulged or which, when opened, are noted to contain gas bubbles, a rancid odor, or a musty and slushy appearance among the solid particles.

2. Thoroughly heat to a boiling temperature before using, all home-canned vegetables. Only boiling for a sufficient length of time after removal from the glass jars or cans before being served or preservation in at least 10 percent brine solution will make home-canned foods reasonably safe.

Congenital Heart Disease

By MELVILLE A. GOLDSMITH, M.D.

The nurse's part in the health supervision of patients with congenital heart disease is discussed in the first of a series of articles by a cardiac specialist

ALL CONGENITAL heart disease is due either to an arrest in development during embryonic life, or to the remains of some part of the fetal circulation, or to some combination of the two. There are many types that cannot be diagnosed during life. Some have so much pathology, and others on the other hand have such slight lesions that it is impossible in either case to make more than a guess at the anatomical diagnosis. There are, however, many cases that can be diagnosed.

Patients with congenital heart disease are relatively few in number, comprising only about three percent of the total cases of heart disease, but they are well worth considering since many of them can be definitely helped if their condition is explained carefully to them, together with the things they should guard against; namely, colds, infections of all kinds, overwork, lack of sleep, and in fact anything that would interfere with their general good health. In these cases a public health nurse may be of great help in assisting the physician to explain all phases of the care and the reasons for it to the patient and parents. Many patients may have a loud, dangerous-sounding murmur, which may not mean so much as to prognosis. These patients may live almost normal lives, with a good prognosis as to length of life and years of usefulness.

A rather workable classification of congenital heart disease is that suggested by Dr. Maud Abbott, which is

based on the presence or absence of cyanosis or delayed cyanosis. She divides cases into three groups: (1) the noncyanotic group, in which there is no cyanosis (2) the delayed cyanotic group, in which there is usually no cyanosis early in life but in which cyanosis may appear later (3) the cyanotic group, in which cyanosis appears early in life.

NONCYANOTIC GROUP

General group

In this group there is no admixture of arterial and venous blood. It includes the following types of defects:

1. Pericardial defects may range from complete absence of the pericardium to the absence of any part. These patients may live a normal life without serious difficulty. They may not be discovered unless fluoroscopic or electrocardiographic studies are made with change of position, showing a shifting of the cardiac shadow under the fluoroscope and changing of the axis deviation in the electrocardiogram.

2. Situs-transversus (dextra cordia) is discovered usually by x-ray pictures. The condition is not incompatible with a normal life.

3. Congenital heart block usually should be looked for in an infant with an apical rate of 40 or lower. These children may live to adult life.

4. Congenital cardiac hypertrophy is a classification applied to cases with much enlargement of the heart, but without any other defect, except that occasionally the left coronary artery

may come from the pulmonary artery. The prognosis is poor. One case observed during the last year died from broncho-pneumonia, at the age of five weeks. A postmortem examination showed the heart to be three times the normal size.

Left-sided lesions

1. Aortic stenosis may be of various degrees and is diagnosed through stethoscope findings by the same criteria as rheumatic aortic stenosis.

2. Coarctation of the aorta is a marked narrowing of the aorta near the ductus. This increases the pressure above the narrowing, causing hypertension in the arms and a reduced pressure in the lower extremities. Diagnosis is made on the basis of stethoscope findings, x-ray pictures, and electrocardiogram. Signs and symptoms are due to hypertension, such as headache, flushing of the neck and face, and dizziness. Weakness of the lower extremities is characteristic. A careful regimen of living and adequate rest are the main therapeutic measures.

Other left-sided lesions that might be mentioned are congenital mitral stenosis (probably due to prenatal rheumatic infection), subaortic stenosis, anomalies of the aortic semilunar cusp, and various anomalies of the aortic arch.

LATE CYANOTIC GROUP

In this group there are three quite common lesions that occur. There is usually no cyanosis early in life, but cyanosis occurs later when any condition appears that might lessen the efficiency of the left heart, or increase the pressure in the right side, thus reversing the flow from right to left.

In this late cyanotic group, patients are subject to subacute bacterial endocarditis and from this standpoint need the same careful advice as to methods of living and avoiding infections, as the rheumatic group of heart cases which are to be discussed in the next article

of this series. In this respect, public health nurses have a definite field of usefulness in caring for these patients.

There are three main conditions in this group which are interesting:

Patent foramen ovale

In this condition, the history is important. Usually there is a story of some cyanosis at birth, possibly lasting for a few weeks thereafter. Then the characteristic thing is transient cyanosis. These cases are diagnosed clinically by stethoscope findings. X-ray findings are important, as they show enlargement of the right atrium. Electrocardiogram usually shows a right ventricular preponderance. Oftentimes these patients are subject to thrombus and occasionally what is known as "paradoxical embolus"—i.e., an embolus which goes into the left ventricle and to the systemic circulation instead of into the right auricle and ventricle to the pulmonary circulation. For moderate cases the prognosis is good for the patient to live to adult age.

Patent ductus arteriosus

Sometimes these patients are under size, frail in stature, and are characterized particularly by transient attacks of dyspnea. Diagnosis is made on the basis of stethoscope findings. Electrocardiogram is not always helpful in diagnosis. Very often this type of lesion will be tolerated very well and the patient will live his normal life span.

Ventricular septal defect

This is a very interesting condition since children who have this lesion have no dysfunction, no cyanosis, and no shortness of breath. Diagnosis is made on the basis of physical findings. X-ray of the heart shows nothing special, except, perhaps a more rounded heart than normal. Electrocardiogram is usually normal. It may show a right axis deviation. These patients may live a normal lifetime.

CYANOTIC GROUP

Pulmonary stenosis

Children with pulmonary stenosis are ninety percent cyanosed and also have clubbing of the fingers. Diagnosis is made on the basis of stethoscope findings; x-ray picture, which shows right-sided enlargement; and electrocardiogram, which shows a right ventricular preponderance. The prognosis is only fair.

Tetralogy of fallot

In this condition, there is always a marked cyanosis with clubbing. The physical findings are characteristic, and the x-ray picture shows a widening of the great vessel area with aorta pushed

over to the right, and right ventricular enlargement. Electrocardiogram shows a right axis deviation. These children may live to early adult life, if they are able to have a good regimen of living, with proper diet, long hours of rest, and modified activities.

There are many other conditions which could be classified under this cyanotic group, but most of them are so severe in character that the life span is greatly shortened.

This is the first of a series of articles by Dr. Goldsmith on various types of heart disease, and the part of the public health nurse in its control. The next article will be on the subject of rheumatic heart disease in children.

News from the S.O.P.H.N.'s

THE TEXAS State Organization for Public Health Nursing was organized in 1922 at Fort Worth, Texas, with 13 charter members. In 1922 it accepted an invitation to become a branch of the National Organization for Public Health Nursing. Our enrollment has gradually increased during the 18 years until now we have 191 members.*

The organization has held a joint meeting each year with the Texas Graduate Nurses Association. For the past four years the State League of Nursing Education and the S.O.P.H.N. have held stimulating joint institutes in November at a central meeting city of this vast empire—Austin. By pooling the resources of both organizations, excellent programs have been arranged.

A School Nursing Section was organized this year, to "enlist the help of the

S.O.P.H.N. in solving the problems of the school nurse." A committee was appointed to outline objectives for school nursing programs in Texas, and another to make plans for an institute for school nurses in the fall.

At our last meeting we voted to send a News Letter to our members at least twice a year. The first letter, which was issued just after the Biennial Convention in Philadelphia, contained a report of the Convention, a report of our state meeting including the names of the newly elected officers, and future plans.

Our dues were raised from \$1 to \$2 a year at the 1939 meeting, and as a result we are closing this fiscal year with a balance of approximately \$200.

We celebrated our eighteenth birthday by the publication of the history of our Organization, which was printed in attractive pamphlet form, and made available for fifty cents a copy.

FAYE PANNELL, R.N.

Secretary-treasurer
Texas State Organization
for Public Health Nursing

*Two of the charter members, Misses A. Louise Dietrich and Mary Kennedy, have been active members in the organization for the entire 18 years. At the last annual meeting, honorary life membership was conferred on both of them.

Health Department in a Hotel

By HAZEL SHAKLEY, R.N.

An industrial nurse working in a hotel has the twofold responsibility of service to guests and service to employees

THE STATLER hotels each have a well equipped dispensary with a full-time nurse in charge and a part-time physician on call. Both live in the hotel in order to be available at all times in case of accident or illness of guests and employees. Hotel nursing, like all industrial nursing, is part of the public health field, so that the more training and experience the nurse has had in this field the better she is able to handle her work. The duties of a hotel nurse are of two types: her work with guests, and her work with employees.

SERVICE TO GUESTS

A guest who is ill in his room is reported to the nurse by the floor clerk, assistant manager, or housekeeper, and she urges him to call the house physician even if the illness is slight. It is not possible for the nurse to give complete nursing service to these guests since she has many other duties. However, she does take the patient's temperature, makes him as comfortable as possible, sees that he has fresh water, and offers other little personal services that he may need—such as making a telephone call for him. Even if she gives no nursing care, but sits for a few minutes and visits with the guest—who is usually frightened and feels very much alone in a strange hotel—he feels that the hotel is looking out for his welfare. If a guest has been well taken care of in a hotel during an illness he is sure to have a friendly feeling toward it.

Accidents to guests in the hotel are given prompt and efficient care. The

nurse gives first-aid treatment until the physician arrives, assists him afterward, and helps to reassure the guest. These patients are always seen by the house physician so that his diagnosis and treatment can be recorded. The assistant manager also sends a detailed report of the accident to the manager's office, and this is forwarded to the insurance company. Factors such as weather conditions, heels on the guest's shoes, wearing of glasses, and any unsafe condition such as foreign matter on the floor are noted in the report.

When guests stop in the dispensary unsolicited for treatment by the nurse, such as a throat spray or dressing to a wound, she refers them to the physician and does not take the responsibility herself.

SERVICE TO EMPLOYEES

The care of the employees may be divided into three parts: first-aid treatment of accidents happening on the job or so-called industrial cases, care of personal illness, and home calls to the sick.

Employees are taught how to be more careful and avoid accidents, but if one occurs the employee reports immediately to the dispensary for care. Here he is given treatment by the nurse or physician and a report of the accident is made by the nurse. The employee is instructed to return the following day if necessary. It is the nurse's responsibility to see that employees injured on the job receive good care, and compensation when it is due.

If the employees have confidence in the nurse they will also come to her for help with personal illness. Minor ailments may be taken care of by the nurse through the standing orders of the house



"How did it happen?" asks the nurse as she gives first-aid care to a kitchen employee who has come to the dispensary with a burned arm

physician. If the same illness occurs repeatedly the nurse encourages the employee to go to his family physician or to a clinic. She is also alert to symptoms which may indicate a serious condition, such as sudden or continuous loss of weight, chronic cough, weakness, loss of energy, or dizziness. Employees with such symptoms are urged to have a thorough physical examination by their family physician.

Employees also bring the troubles and ailments of their friends and families to the nurse for advice. Here she has a chance to give instruction and suggestions for a healthful regimen of living and where necessary to refer them to social agencies, dispensaries, and other community agencies which can help them with their problems.

All employees report to the nurse before going off the job ill. When they have been absent three days the department head notifies the nurse. If the employee is a member of our group insurance plan with the Metropolitan Life Insurance Company, one of the insurance nurses may make the home call and

report back to the hotel nurse. In Cleveland this work is done by the Visiting Nurse Association, which has a contract with the insurance company. If the employee does not have group insurance or if he is ill in the hospital or at home for a long period of time the hotel nurse may want to make the visit herself. She may get a better understanding of the worker and his illness when she sees his home environment. She often sees problems in the home that may be the cause of the employee's illness. Here again she often has opportunities for health education. At no time should the nurse make police calls to see why the employee is not at work. This is for the department head to do.

ASSISTING WITH EXAMINATIONS

The nurse helps the physician with preemployment physical examinations of new employees. If the employee has a defect which can be corrected, such as carious teeth or defective vision, he is referred to a dentist or ophthalmologist for correction before he starts to work.

Food handlers are examined once a year. Each city has different regula-

tions on this matter and the hotel follows those of the city health department. Food handlers are carefully questioned as to their history of typhoid fever, since a Typhoid Mary can cause a great deal of trouble in a hotel. If tests for syphilis are found to be positive the hotel requires the employee to have treatment from a reliable physician or clinic if he wishes to continue his job.

Employees who lift heavy weights, such as bellmen, porters, and housemen, are examined regularly for hernia.

The nurse is a member of the safety committee, which meets twice a month. Once a month all new employees hired during the previous month are invited to attend this meeting. They are welcomed to the hotel and told the purpose of the committee. They are asked to report accident hazards around the hotel, and any other suggestions for preventing accidents are welcomed. Emphasis is laid on the importance of reporting an

accident promptly and having immediate treatment, no matter how minor the injury may be. At the second safety meeting of the month all employees who have had accidents during the previous month are invited to tell how the accident happened and how it might have been prevented. This is not a means of punishment but a matter of education.

TYPES OF RECORDS

The files and records are the nurse's responsibility. Three active files of employees are kept. Each employee has a white card on which are noted his name, department, clock number, and a notation as to whether he has group and hospital insurance. All of his industrial accidents are recorded on this card as well as any other information or history that the nurse believes might be valuable in the future. Personal notations, too, may be made by the nurse. The second card, a blue one, is his physical examina-



The guest feels reassured when the hotel nurse comes to see her

tion record, which is made out and signed by the examining physician. A third, smaller white card is kept for all food handlers. A duplicate copy is sent to the health department, which passes on the food handler and issues him a certificate. Here again each city has a different procedure regarding the handling of food. When an employee leaves our employ his records are placed in an inactive file.

Three monthly reports are sent to the manager's office. One shows the time lost—if more than a week—of each employee due to accident or illness. The second shows all the accidents which employees have had during the month and whether there was any time lost. The third is a monthly summary of all food handlers examined.

If an employee has been absent because of illness a week or more he sees the nurse before his return to work. The department head gives the returning employee a return-to-work form which he takes to the dispensary. The nurse or physician marks approval or disapproval, and the slip is returned to the department head. Each time the employee has an accident the nurse makes out the accident report and it is sent to the department head for a signature. All of the details of the accident are

reported on this form. The nurse also keeps a daily notebook record of all the patients she sees during the day.

Opportunities are utilized for health education of the individual employee. Many fears and superstitions may be eliminated in this way. Safety movies are shown to the employees in large groups. Posters and literature from the insurance company are another means of education. Seasonal memoranda on hygiene are sent out to the department heads to be posted in their departments, containing suggestions on matters such as the prevention and treatment of colds in the winter, and advice about sunburn and swimming in unsafe places in the summer.

The nurse should be familiar with different community agencies so that she may refer employees and their families to them as needs arise.

Of course, before any of this work can be accomplished by the nurse she must have the confidence of the employee and the coöperation of the management and department heads.

The Statler hotels believe that their health service pays for itself in good will of guests and employees, in lessened employment turnover; in reduced loss of time due to illness and accidents; and in decreased compensation claims.

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Jewish Dietary Laws and Food Customs

By BELLA CASSEL

The public health nurse who wants to do effective teaching will acquaint herself with the racial and national customs of the families with whom she works

JEWISH PEOPLE have through the centuries wandered into all parts of the world, and their diet, therefore, is probably more varied than that of any other people. They have carried with them, wherever they have migrated, the styles of cookery prevailing in the countries from which they have come.

From Spain and Portugal they have carried away, along with their fondness for olives, their custom of frying fish and other foods in oil. From Germany they have taken the habit of the "sweet and sour" stewing of meats and vegetables, where a kind of salt called "sweet and sour" is used as part of the seasoning. To Holland they owe a taste for pickled cucumbers and herring, and from here also come such Jewish dainties as butter cakes and *bolas* or jam rolls. From Poland, Jewish immigrants have brought into their new homes *lokschen* or *frimsel* soup, cooked with goose fat, stuffed fish, and various kinds of stewed fish. Most of the dishes cooked by the Jews in eastern Europe are like those of the people among whom they dwell. The *kasha*—made from barley and grits, a coarse grind of white cornmeal—and *blintzes* come from Russia. The *mami-liga* comes from Rumania; the *paprika* from Hungary.

The Jewish dietary laws are quite complicated. The permitted food is labeled "clean," or pure. A forbidden food is not simply "unclean," but is considered impure and positively contaminated.

PROHIBITED FOODS

Certain foods are prohibited by orthodox Jewish law. The products of animals that are suffering from some disease, that have even died a natural death, that have eaten poison, or that do not have a cleft hoof or do not chew their cud, are regarded as unclean, and may not be used for food. Pork, therefore, cannot be used in any form by the Jewish person who follows the traditional religious laws. In addition, the hindquarter of animals must not be eaten. They may, in consequence, choose meat only from the forequarter of the animal, and the tougher cuts come from this part. This explains some of their meat dishes, which are often long cooked and highly seasoned. The cuts which may be cooked quickly, such as steaks and chops from the tenderer hind quarters, may not be used.

RULES ON SLAUGHTER OF ANIMALS

Only a *shochet* who has gone through special training can slaughter cattle and poultry. He must use a particular knife which is called a *halif*. The *shochet* is under the supervision of a rabbi. The Jewish dietary laws require that as little pain as possible be inflicted on the animal being killed.

The orthodox housewife then buys her meat at a so-called *kosher* butcher shop, where she can be sure the meat has been killed under the accepted conditions, and is meat from a freshly killed animal. This of necessity makes meat so closely supervised and shipped as live

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weight to the place of sale more expensive than in the ordinary butcher shop. This is, of course, a great hardship on those dependent on relief and on the many whose working incomes are extremely modest. Some meats are as much as twenty cents a pound more than in a regular market catering to the general population.

FOOD PREPARATION

Since the blood of an animal is prohibited as food in the Jewish household, the meat is soaked for a half hour and salted on all sides for an additional hour. After the meat has been salted the allotted time, it is washed thoroughly and is then ready for cooking. This process is called *kosher* and is considered very important.

In the preparation of poultry, the insides must be removed before *kosher*. The head must be cut off, and the skin of the neck turned back or cut to remove the vein lying between two tendons found there. The heart of the fowl may be used, but it must be cut open lengthwise and the tip removed before soaking, making it possible for the blood of the heart to flow out more freely.

FISH USED FREELY

Fish is well liked and used generously by these people with origins in many countries. All fish which have fins and scales may be eaten. This bars shellfish, such as oysters, clams, and lobster. The origin of this prohibition probably lies in the fact that the waters in the countries where these people lived in early times were polluted most of the year. There may also have been cases of poisoning resulting from mistaking poisonous water snakes for eels, and so there arose the rule that fish must have scales to be acceptable. From early times as far back as their stay in Egypt, Jews have shown a strong liking for fish, and have developed special skill in its preparation.

There are many reasons for this preference. It was more easily obtainable than meat. It is not regarded as meat and may be seasoned with butter—prohibited with meat by religious law. There are seasons such as the Nine Days, when strict Jews abstain from meat altogether. Fish is a welcome main dish at these times. The Jewish people from inland countries like Poland are limited to fresh-water fish. Anglo-Jewish methods of cooking fish were first introduced by Portuguese Jews and copied by those from Germany. Their favorite fish is salmon, which is either fried or stewed. Smoked salmon is another Jewish delicacy, and this, together with pickled herring and pickled cucumbers, is often to be seen at the Jewish table, whether they observe the orthodox dietary laws or not. Gefüllte fish is familiar to many people, non-Jewish as well as of the faith, and probably originated in Germany. This is really a fish skin stuffed with a mixture of chopped fish, raw eggs, grated apple, and soft bread, seasoned with salt, pepper, and a little sugar. The stuffed fish skin is then stewed in tomatoes, onions, and carrots until cooked. This popular delicacy is served with horseradish.

FOWL AND BIRDS

Fowl and birds are well liked also, but there are rules governing their choice. The clean birds by definition of the dietary law have craws, and their stomachs have a double skin which may be easily separated from the bird's carcass. These birds will catch food thrown into the air, but will lay it upon the ground and tear it with their bills before eating it. If, on the other hand, crumbs be thrown to an unclean bird, the food will be caught in the air and swallowed immediately by this kind of bird. There has been much speculation as to the reason why certain species of animals should be allowed as food and others forbidden. Students of the subject

explain that these laws were given to the people to teach them justice and to awaken pious thoughts and thus build character in the Jewish race. There is especial stress laid on the fact that birds of prey are forbidden, in order to teach that man shall practice justice and not use his strength to injure others.

MILK AND MEAT COMBINATION

Since the Bible states that there can be no seething of the kid in its mother's milk, the law prohibits the serving or eating of milk and milk products with meat. It was apparently unthinkable to the ancient religious Jew that a kid's meat might be boiled in the milk of its own mother. In a way not explained by those I asked, and probably having originally a far deeper mystical meaning, this idea carried over to prohibit the combination of milk and meat in any fashion.

Milk or milk dishes may be eaten before but not with meat, and they may not be used in the preparation of meat. The law requires that one wait six hours before eating milk products after meat has been consumed.

It is necessary to have two sets of dishes, silverware, and cooking utensils, since dairy products must never be served on a dish which has had meat on it. In earlier days this was a wise precaution when wooden bowls were used. Wood which is porous absorbs meat juices and holds bacteria. Milk readily takes up flavors and odors and is less appetizing to drink when it has the taste of meat. The meat juices and the bacteria absorbed by the wood might also contaminate the milk and make it putrefy and therefore become unfit for food. The fear of such contamination has carried over even though for generations we have had metal pans in the kitchens and smooth china which can be thoroughly cleaned on our tables. The fact that glass dishes may be used to serve both meat and milk products lends

weight to this explanation for the separation of milk and meat dishes.

The regulation to prohibit serving milk and meat products together also limits menu planning. For example, a Jewish housewife could never make a white sauce with milk and add the left-over bits of meat, to serve creamed meat on toast. Even more limiting, she may not butter the vegetables to be served with the meat dinner, nor put cream on the table for the dinner coffee. This partly explains why vegetables are less used in orthodox homes, or in families which have given up orthodox customs but quite naturally carry on the habits of their parents. There is good reason for the universal habit of serving only a cabbage salad seasoned with herring and a vegetable oil with the meat meal.

THE SABBATH

Because there can be no cooking on the Sabbath, which comes on Saturday, the traditional seventh day, the Jewish housewife has to prepare two-days' meals on Friday. The main dish for this sacred day is the *kugel*, which usually consists of meat stewed with peas and beans. It is placed in the oven before the Sabbath begins. The fire having been made and the oven tightly closed to retain the heat, the dish requires no further attention and will hold its heat until it is wanted for the Sabbath mid-day meal. The fact that there can be no cooking on this holy day explains why fried fish is eaten cold and liked. Stewed fish is also eaten without being warmed. An important feature of Sabbath cooking is the preparation of twists of bread which are known as *khalahs* or in southern Germany, Austria, and in Hungary, as *barches*.

Another item which has become traditional is raisin wine. Jewish people are required to offer over a cup of wine the Sabbath prayer for the Sanctification of Food. In many countries wine was too expensive for the majority of Jewish

families. A cheap preparation made of boiled raisins was therefore substituted. Its use, though it resembled wine very little, satisfied all the requirements of the treasured ritual. At present the customary wine made from fresh grapes is used for this ceremony.

FOOD FOR THE HOLIDAYS

During the eight days of Passover, which falls about the same time as the Christian church's Easter holiday, no leavened bread or its products may be eaten. The Jewish household undergoes a complete cleaning, and it is important that every bit of bread be removed from the house. This holiday necessitates the use of two different sets of dishes, silverware, and cooking utensils. Matzoth, an unleavened bread familiar to many, is eaten instead of bread. Matzoth meal is used in the preparation of matzoth klos (dumplings), cakes, and puddings. During the holiday a great deal of fat is used in the preparation of foods, usually chicken drippings or beef fat.

Yom Kippur, or the Day of Atonement, is a fast day. No food is to be eaten from sundown the evening before the holiday until sundown of the holiday. The orthodox Jews observe this day very carefully. It is particularly hard physically on the old people to spend the entire day in the synagogue with nothing to eat—not even water to drink. A child at thirteen must join his elders in this yearly fast, and is urged to observe this important day even as early as eleven years of age.

Certain foods are characteristic of the various holidays. Dairy dishes because of their whiteness are served on Shevuoth, the Feast of Weeks. Triangular cakes called Haman taschen and stuffed with poppy seeds and honey are served on Purim to symbolize the wicked Haman, whose aim was the extinction of the Jewish people. These cakes were made in the shape of the hat Haman wore, which was triangular.

The Sabbath is habitually honored by special foods, usually chicken or gefüllte fish. To buy expensive foods for this religious day often means that the family on relief or low income has less food during the week. This is, of course, particularly hard on the children.

FOOD VALUES

The Jewish diet tends to be more than adequate in protein, since eggs and meat or fish and meat are often served at the same meal. The dark fresh breads, such as rye and pumpernickel, are most popular. Their habitual use of the whole grains has been a wise custom, since all through the years this food assured them a good source of vitamin B and iron in their diets. Bread is, however, used somewhat more liberally than is usually necessary. Their generous servings of bread make their diet too high many times in caloric intake, and so encourage the overweight common among this people who need to avoid obesity, since that condition often accompanies diabetes. Because by inheritance they show a predisposition to this disorder, students of diabetes state that Jewish people, particularly the women, should be especially careful of overweight.

Partially because milk dishes cannot be eaten at the same time as meat dishes, the followers of the rule limit the use of milk. The Jewish people nevertheless eat many kinds of cheese and also sour cream, and thus partially make up for what would otherwise be a very low calcium intake. They would be wise to use more liquid milk and are learning to give more of this food to their children. In fact, often physicians and those of us teaching mothers about food values are forced to urge the oversolicitous parent to decrease the amount of milk as well as other foods which are being forced by coaxing and pleading on the already well nourished child. Jewish parents are particularly anxious that their children be well fed and are some-

times quite concerned over a child whose appetite is normal but to them seems too dainty.

The Jewish people use potatoes generously, and so add not only an inexpensive source of fuel but of iron and vitamin C to their diets. It is more difficult to teach the value of the lighter green vegetables, since they seem less nutritious. Jewish families of the United States, with its year-round supply of fresh and canned and frozen vegetables, are becoming more and more aware of the role these foods play in the diet, and are using them, usually with the so-called dairy meal. Their wide use of such legumes as lentils and dried lima beans has been an excellent dietary custom which has added a good iron supply and brought them proteins, though of an incomplete type.

THE JEWISH DIABETIC PATIENT

The Jewish diabetic patient affords a great problem to the doctor and the dietitian working with him in the hospital. Because of the training of the orthodox Jewish person, it is very difficult and sometimes even impossible for him to eat meat with milk products. Though he may be very anxious and conscientious about carrying out the doctor's instructions, the sight of butter or milk on the same tray with meat sometimes will ruin his appetite for the entire meal.

This feeling of not mixing is deep-rooted in the Jewish person, and he can no more think of eating milk and meat at the same meal than the religious Catholic can take meat on Friday without a feeling of guilt. It is therefore important that this be taken into consideration when meals are being planned for the Jewish patient. If the physician can give the dietitian the patient's dietary orders for the entire day, and she is well versed in the Jewish rules governing diet and is acquainted with some of the favorite dishes and com-

binations and possible substitutions for the usual carbohydrates, she can plan meals which will more nearly please the patient and insure his eating what has been ordered.

It is necessary that his meals be planned in such a manner that there be no conflict with his beliefs. It may be possible to plan so that he has his eggs, cereal, and milk in the mornings, his meat and vegetables and a fruit dessert at luncheon, and the dairy products along with the other vegetables at his evening meal. This kind of planning can well be extended to other patients on other types of ordered diets.

It is most important, of course, for the diabetic whose food is weighed that he eat all of the food on his tray. He will not feel that being on a diabetic diet is such an ordeal if he occasionally gets foods to which he is accustomed, such as cottage cheese and sour cream, or sour cream mixed with vegetables, or salads made with whitefish or with cottage cheese. At best he will miss the pickles, sour tomatoes, and high seasoning to which he has been accustomed. The Jewish orthodox patient as well as those of all faiths and customs welcomes foods in the hospital which are similar to those he has at home. Seeing some of the familiar foods will help as much as almost anything to make his stay in the hospital easier and pleasanter. For rapid recovery it is important that his diet shall not be deficient, but well balanced and rich in all the food essentials, particularly the vitamins and minerals.

A typical Jewish family of moderate income would have meals at home similar to the three meals given in the menu which follows:

Breakfast—a dairy meal

Prunes or orange juice
Oatmeal or farina with milk or cream
Cheese, or smoked salmon, or sardines
Crusty white rolls with sweet butter
Coffee

Luncheon—a dairy meal

Borsch (beet soup) with sour cream and boiled potatoes
 Baked fish, lettuce and tomato salad with oil dressing
 Rye bread with sweet butter
 Apple sauce and sponge cake
 Tea or milk

Dinner—a meat meal

A meat stock soup
 Roast meat or pot roast
 Pickles or sour tomatoes
 Roasted potatoes
 Carrots and peas
 Rye or pumpernickel bread (without butter)
 Stewed prunes or mixed fruit—piece of strudel
 Tea with lemon

SUGGESTED CHANGES IN DIET

Analyzing the day's menu of a typical Jewish family, one can ask for only a few changes:

1. That a green vegetable sometimes replace the usual carrots and peas.
2. That when fresh tomatoes are not in season, other salad greens be used instead of hothouse tomatoes, and that canned tomatoes be served often perhaps

as escalloped or stewed tomatoes or soup.

3. That fresh fruit replace the cooked fruit at one or two meals.

4. That milk to drink be supplied for the children at the dairy meals.

5. That occasionally milk pudding or custards or milk soups be served. When evaporated milk is less expensive than bottled milk, it can be used to make such dishes, and more milk can be incorporated into the diet at less cost.

6. That no coffee or tea be given children.

7. That only moderate servings of butter be used, and less fat in cooking foods.

The Jewish custom of using cheese, eggs, dark breads, and cereals, potatoes, cabbage, the dried fruits, dried legumes, fish, and the cheaper cuts of meat is certainly to be applauded and encouraged. They need only learn to make use of the fine supply of fresh vegetables in this country, and sometimes to serve more liquid milk.

NURSE PLACEMENT SERVICE

announces the following placements and assisted placements from among appointments made in various fields of public health nursing. As is our custom, consent to publish these has been secured in each case from both nurse and employer.

*Mary Victoria Adams, Supervisor, Wood County Chapter, American Red Cross, Parkersburg, W. Va.

*Blanche George, Supervisor, Instructing Visiting Nurse Society, Washington, D.C.

*Emma Kuehlthau, Educational Director, Visiting Nurse Association, St. Louis, Mo.

*Evelyn C. Nelson, Supervisor, Wexford

*The N.O.P.H.N. files show that this nurse is a 1940 member.

County Maternity Demonstration and Generalized Service, State Department of Health, Lansing, Mich.

*Marian T. Petraske, Generalized Supervisor, Visiting Nurse Association, Scranton, Pa.

Valerie C. Drew, Field Industrial Nurse, Employers Mutuals of Wisconsin

*Cora M. Golden, Field Industrial Nurse, Employers Mutuals of Wisconsin

*Helen T. Donelan, Industrial Nurse, National Youth Administration, Chicago, Ill.

Gertrude L. Anderson, School Nurse, Decatur Public Schools, Decatur, Ill.

Ella Mae Chambers, County Nurse, Osceola County, State Department of Health, Des Moines, Iowa

*Mary Flanigan, County Nurse, Crawford County, State Department of Public Health, Springfield, Ill.

Elizabeth Hittle, Health Nurse, Illinois Children's Home and Aid Society, Chicago, Ill.

(Continued on page 691)

Nursing in Programs for Crippled Children

By HORTENSE HILBERT, R.N.

An interesting review of public health nursing in state services for crippled children in nine states of the northeastern region of the United States

THE VARIETY of state agencies responsible for administering services for crippled children under the provisions of the Social Security Act is not so great in the northeastern area of the United States as it is in the country as a whole. In the northeastern area, the state agency is in every case but one the state department of health, the exception being the New Jersey Crippled Children Commission. In the 51 states, the territories, and the District of Columbia, however, these services for crippled children are administered by 26 state departments of health, 14 state departments of welfare, 5 state departments of education, 5 crippled children's commissions, and 1 state university.

In the northeastern area, medical direction is provided in all the state programs which have developed through the Social Security Act for the care of crippled children. In seven of the nine states in this area, the administrators of the entire state program are physicians, either pediatricians or orthopedists. In the other two states the administrators of the entire state program are not physicians, but medical advice is provided through orthopedists on the staff. Orthopedists are employed for clinical services in every one of the state agencies. In all these agencies, physical-therapy technicians are assigned to the clinical centers, and in some agencies these technicians carry on field work and are directly attached to the field staff of the state agency.

NURSING PROGRAM IN NORTHEAST

In considering more specifically the nursing aspects of the program in these nine northeastern state agencies, it is of interest that special staffs of nurses, giving direct services to crippled children to varying extents, are attached or assigned to the crippled children's division or agency in three states—New York, New Jersey, and Rhode Island. In Vermont there are three nurse physical-therapists, including the director.

In two of the states just mentioned, New Jersey and Rhode Island, the number of special orthopedic nurses on the staff is very small (two or three), and orthopedic nursing services are also given—perhaps the greater part of them—by general public health nurses employed directly by the state department of health, local departments of health, or other local health agencies. In these two states it is definitely considered to be a function of the special orthopedic nurses to assist the general public health nurses in the care of children requiring orthopedic nursing.

In Connecticut ten field nurses in the Bureau of Child Hygiene combine services to crippled children with maternal and child health services. Here, too, it is intended that these workers help the local general public health nurses with orthopedic nursing problems.

In New York and Vermont, where the nursing service is probably administratively the most specialized at the moment, there seems to be a tendency to

expect the general public health nurses gradually to assume more and more responsibility for general nursing care and health supervision of crippled children, although the special worker still retains the major proportion of all nursing services for this group of children.

Five of these nine state agencies, then, employ special orthopedic field nurses to some extent for direct services to crippled children, and in three of the agencies orthopedic nursing services are to a large extent combined with general public health nursing. Special orthopedic nursing supervisors are also employed in these five agencies, who, in addition to supervising the activities of the special orthopedic nurses, act also in the capacity of orthopedic nursing consultants to the general public health nurses in the state department of health or to local nurses outside the department of health.

In the four states where no field nurses are directly attached to the crippled children's division or agency and none are assigned for special services, provisions are made for orthopedic nursing consultants in the division of public health nursing. Because of the scarcity of public health nurses well qualified for orthopedic nursing consultation, these positions are not all filled at present.

NURSING PREPARATION NEEDED

Some intensive preparation in orthopedic nursing is considered necessary for every public health nurse who gives orthopedic nursing services to crippled children, whether she is a special orthopedic nurse or a general public health nurse who includes it as part of her services in child health supervision. This is particularly true in view of the fact that during their basic course in nursing many nurses had no systematic preparation for the orthopedic nursing of children, and comparatively few have had experience in this field since graduation. In any case, it is now quite generally

believed that at least the amount and kind of training prescribed in the new curriculum guide of the National League of Nursing Education should be part of the equipment of all public health nurses who give nursing care to crippled children. It is quite generally agreed that public health nurses who are expected to function as teachers or consultants in this particular type of service need advanced preparation in orthopedic nursing in addition to full preparation for public health nursing supervision.

Three schools in the northeastern area now offer such advanced courses: Columbia University, New York University, and Simmons College at Boston. A joint committee of the National Organization for Public Health Nursing and of the Committee on the Care of the Child of the National League for Nursing Education has recently prepared an outline suggesting desirable content and clinical practice for such a course. This outline has been approved by the Council on Orthopedic Nursing and the Education Committee of the N.O.P.H.N. as a tentative guide to universities offering such a course.

It is considered important that the public health nurse have the technical training that can be obtained only through an approved course in physical therapy* if she is expected to include in her services to crippled children orthopedic physical-therapy treatments which require training that she did not receive through her course in orthopedic nursing. Similarly, it is considered necessary that the orthopedic nursing consultant or supervisor who is expected to combine physical-therapy supervision and instruction with her orthopedic nursing consultation have the dual preparation implied by this dual function.

*Approved by the Council on Medical Education and Hospitals of the American Medical Association.

Stipends have been granted to a considerable extent in the northeastern area to assist public health nurses in various types of positions in state or local official agencies in acquiring this special training or experience in orthopedic nursing. Nurses who have had adequate preparation in orthopedic nursing, but have not been thoroughly prepared for public health nursing, have also been provided with opportunities, through stipends, for further study.

CONTINUOUS STAFF EDUCATION

It is realized that, in addition to requiring this fundamental preparation for the job, every agency must provide continuous in-service or staff education and individual consultation on the orthopedic aspects of nursing care from someone well qualified to give it. The best way for the public health nurse to acquire insight into the particular requirements of crippled children as well as competence in giving them nursing care is through special courses in orthopedic nursing, in addition to courses in public health nursing, and through continuous in-service training.

Regional conferences of nurses offer opportunities to probe together questions of mutual concern and to exchange the experiences of several years in a particular field which has recently become more conspicuous because of special federal-state provisions for the care of crippled children. Public health nurses have always to some extent given care to these children. However, provisions for care have become more extensive, more systematically organized, and more evenly distributed among the states and within the states as a result of the Social Security Act.

TYPES OF SERVICE RENDERED

I think it can be said without reservation that all public health nurses who give general family health services have some responsibility for the crippled

child, as they have for other children in the family, whatever the health condition. However, I do not believe that we can with equal assurance at this moment state which specific types of orthopedic nursing services a general public health nurse can be expected to give. As has been mentioned before, there are great variations in the amount and quality of the training in orthopedic nursing that public health nurses have had as part of their basic nursing preparation. Moreover, the development of organized units of study for graduate nurses who need training of a type that their schools of nursing did not include as part of their undergraduate courses has not advanced as rapidly as the demands.

Although no formal, planned job analyses have been made of the orthopedic services given by general or special public health nurses or by nurse physical therapists (and they are at the moment badly needed), we know from observation, experience, and review of reports of activities that some or all of the following types of service are being given:

Under general medical direction

Health supervision from birth to school age, which includes nursing care and instruction in nutrition, immunization, daily regimen of the child, correction of physical defects, and so forth, and which is needed by every child throughout his childhood no matter what his health condition may be.

Under individual medical direction

Care of the sick child during acute and chronic illness and care during and immediately following such illness to prevent deformities; supervising, others and teaching them how to give such care. Such acute and chronic illness includes poliomyelitis, tuberculosis, osteomyelitis, arthritis, and so forth, that may result in disability that subsequently requires orthopedic care.

Nursing of the crippled child whose condition requires orthopedic care. Such nursing includes massage, helping to maintain the proper position of the child's body, care of casts, splints, braces, and other appliances.

Interpreting to the parents the instructions for muscle exercises and assisting them in giving these and other treatments to be carried out in the home.

Sometimes periodic grading of muscles in order to report to the physician on the progress in restoration of muscle function.

The public health nurse is generally expected to acquaint the family with the resources of the community for education, vocational guidance, economic aid, and social services; and she is also expected to keep the community informed as to the adequacy or inadequacy of re-

sources available to the community for crippled children. Moreover, in her general family health service the public health nurse, of course, contributes consciously or unconsciously to the prevention of crippling.

Presented before the Northeastern Regional Orthopedic Nursing Conference, February 8, 1940, New York, New York.

NURSE PLACEMENT SERVICE

(Continued from page 687)

- *LaVerda T. Hunsinger, Staff Nurse, Tuberculosis Institute of Chicago and Cook County, Chicago, Ill.
- *Mary E. Leighty, School Nurse, Forest Park Public Schools, Forest Park, Ill.
- Clyda M. Moses, Staff Nurse, City Health Department, Fargo, N. Dak.
- Grace Myers, Supervising Nurse, Alton Public Schools, Alton, Ill.
- Mrs. Eardie C. Peil, Community Nurse, District Nursing Association of Northern Westchester County, Mount Kisco, N.Y.
- Helen I. Schaumberger, Community Nurse, American Red Cross, Montrose Chapter, Montrose, Pa.
- *Rosannah Shaver, School Nurse, City Schools, Brookings, S. Dak.

ASSISTED PLACEMENTS

- *Dorothy Dilts, Reserve Counsellor, W. K. Kellogg Foundation, Battle Creek, Mich.
- Grace Beers, Staff Nurse, Public Health Nursing Association, Pittsburgh, Pa.
- *Mrs. Katharine G. Hunter, County Nurse, Butte County, Calif.

The most urgent demand as time marches on is for nurses in one-nurse services in the public health nursing field. These are in counties and small towns throughout the country. Most of them are in generalized programs—usually with bedside service if in a privately financed agency and usually without

bedside service if in an official unit. There is always a sprinkling of specialized services such as venereal disease, orthopedic, and maternity and child health programs. The positions in child health rose to a high peak during the summer when camp nursing (temporary) and school nursing (permanent) positions need filling.

The requirements are universally high now that standards of the National Organization for Public Health Nursing are quite generally accepted and are being promoted by such organizations as the American Red Cross, the U. S. Public Health Service, the U. S. Children's Bureau, and state departments of health. Also, the steadily growing adoption of merit systems in the official services is a factor. There would probably be enough nurses for all the vacancies had experience not proved the wisdom of adhering to the minimum requirements of completion of the full one-year approved program of study obtained in universities, with at least one year of experience, preferably generalized, under adequate supervision—which can only be obtained in a well organized community service with a well prepared public health nurse in charge.

ANNA L. TITTMAN, R.N.
Executive Director

College Nursing Round Table

A summary of the Round Table on College Nursing, Biennial Convention, Philadelphia, Pennsylvania, May 16, 1940

THE AIMS of this first round table on college nursing at a Biennial Convention were to create an awareness of the problems in college nursing, to gather together the information available on this field, and to discuss the future contribution of college nursing to our democracy. The tremendous responsibility of college nurses in the training of future leaders in personal and public health was emphasized by the chairman, Raidie Poole, of State Teachers' College in Superior, Wisconsin. A report on the study of college nursing services made in 1939 by the Subcommittee on College Nursing Services of the School Nursing Section of the National Organization for Public Health Nursing* was given by Catherine Vavra, of State Teachers College, Duluth, Minnesota.

VARIATIONS IN PROGRAMS

Variations in types of colleges and in their health programs were discussed by Jane Foster of Smith College, Northampton, Massachusetts. Factors which affect the scope of the health service were mentioned, such as the size of the budget, the location of the college, the number of dormitory students, the relative economic dependence of the student body, the education philosophy of the institution, and the personnel of the college administration. Miss Foster emphasized, however, that the variable of most significance and also perhaps most subject to control is the personnel of the health staff itself, and their concept of their own job. Many problems

peculiar to the college group, such as parental relationships, need for vocational choice, relationships with the opposite sex, and financial and academic problems are often revealed in the student's contact with the health staff about some comparatively minor ailment. The nurse must realize that she has some responsibility for the student's general development and adjustment to college, and in being part of an educational institution.

FOLLOW-UP IS IMPERATIVE

The importance of adequate follow-up in the health program was stressed by Adah Rury of Wheaton College, Wheaton, Illinois. She stressed that parents should consider the quality of the health service in choosing a college for their children. The entrance health examination is of limited value unless there is also educational work and follow-up. Studies of college services† have shown that only one fourth of the institutions have arrangements for bringing the defects discovered in the examination to the attention of the student. A discussion of the findings with the student is of great value, in order to interpret the results, to give advice, to reassure some students, and to help form a wholesome attitude toward health. In addition to a conference with the student to interpret the results, the health service must guide him to facilities either in or outside the institution, for the remedying of defects. How far the college itself goes in providing for this remedial care must be determined by each institution. Above all the student must be impressed with the desirability of early attention to

*See "A Study of College Nursing Services," by Fern A. Goulding, PUBLIC HEALTH NURSING, May 1940, p. 319.

† See The Health of College Students, by Harold S. Diehl and Charles E. Shepard, published by the American Council on Education, Washington, D.C., 1939.

defects, and the need for good care. Also, as part of good follow-up work, other college personnel, such as physical education personnel and deans, should be informed of findings which are important in planning the student's college work.

THE INFIRMARY

The college infirmary was discussed by Elsa M. Juhre, of Colorado College, Colorado Springs, Colorado. There is a great deal of variation among infirmaries in regard to organization, administration, and procedure. Except in very large institutions the outpatient department is usually combined with the infirmary. Two classes of ailments are cared for—those resulting from deficient care and education before entering college, and those associated with the college environment. Early bed care as a means of preventing more serious results should be stressed. Patients are usually admitted to an infirmary on the recommendation of the physician if they have symptoms of illness, particularly in case of an elevated temperature. They may be also admitted for observation, for excessive fatigue, and for mental disorder. There should be facilities for enlarging the infirmary in case of an epidemic. For care of ambulatory patients there should be standing orders, and provision for further orders to be obtained as necessary. Care for acute illness requiring surgical care is usually arranged in local hospitals.

A committee from the administration and faculty serving as a lay advisory committee can do much to assist the health staff.

THE NURSE AS HEALTH EDUCATOR

The responsibilities peculiar to the nurse in a teachers' college where she is primarily a health educator were dis-

cussed by Jessie T. Prisch, of State Normal School, New Paltz, New York. A health council in the college is almost a necessity, and the directing influence in this council is the nurse. An awareness of health needs and problems must be created in the student who is to become a teacher. The fact that health is a factor in selection for admission and also a part of the record in the placement bureau makes it doubly important to the student. The nurse also teaches or directs health courses, both in personal and community hygiene, and relates health to the work in sociology, economics, and science. This interrelation can be accomplished through discussion in the health council. The nurse in the teachers' college is therefore a health educator, a teacher, and a health counselor.

A GROWING FIELD

The increasing importance of college nursing as a field of public health nursing was stressed by Dorothy Deming, general director of the National Organization for Public Health Nursing. Miss Deming suggested that if college nursing is a field for public health nurses, the steps in setting standards in the field will include a job analysis (already begun in the study referred to above), the formulation of objectives, a statement of minimum qualifications, and an interpretation to employers of the standards regarding functions and qualifications of the nurse.

At a meeting of the Subcommittee on College Nursing Services of the N.O.P.H.N. School Nursing Section following the round table, plans were made to continue on a broader scale the study begun last year in a limited area.

JANE FOSTER, R.N.
Northampton, Massachusetts

Your N.O.P.H.N.

TWO STUDENT nurses who had collected free samples from all the commercial and professional exhibits at the Biennial Convention arrived at the N.O.P.H.N. booth just after the last orthopedic reprint had been given out. As they signed the order blank for copies to be sent them and glanced again at the models of improvised appliances and the pictures displayed in the booth, one student inquired, "When we get these will we have all the knowledge?"

The dozens of letters which come to the N.O.P.H.N. every month indicate the eagerness with which nurses in all parts of the country are seeking guidance about preparation for orthopedic nursing. The orthopedic service of your National Organization, which is made possible by a grant from The National Foundation for Infantile Paralysis, has focused its efforts particularly on helping the general staff nurse function more effectively in the recognition and prevention of crippling conditions, and in the nursing care and health supervision of patients with orthopedic disabilities.

STAFF NURSE IS KEY PERSON

Why the general staff nurse? Twenty-three thousand public health nurses engaged in maternal and child health services, school nursing, industrial nursing, bedside care, and health supervision have widespread opportunities for early recognition of orthopedic defects and for helping to arrange medical care and home follow-up. Some studies show that 25 percent of orthopedic disabilities are present at birth; approximately 70 percent of the crippling of patients under twenty-one years of age occurs before the age of six.

The general staff nurse can also make an important contribution in the preven-

tion of crippling by: (1) helping to correct environmental factors which cause the crippling disease (2) preventing contractures and deformities such as drop feet, or hip and knee flexion contractures, through attention to the posture of patients confined to bed or chair (3) encouraging regular medical supervision. Early treatment lessens the degree of the disability, shortens the time required for treatment, and saves time and money of the family and community.

The general staff nurse cannot give these services unless she has preparation for the work. Your N.O.P.H.N. is giving immediate assistance through the preparation and distribution of educational materials. A bibliography on orthopedics and care of the handicapped, and articles on orthopedic subjects reprinted from *PUBLIC HEALTH NURSING* are available free of charge. A manual on orthopedic nursing is being prepared. The chapter on "The Nursing Care of Patients with Infantile Paralysis" has been published in pamphlet form and is available without charge from The National Foundation for Infantile Paralysis, 120 Broadway, New York, N.Y. A book of pictures showing improvised apparatus and desirable positions for the protection of muscles in neutral positions, a folder of orthopedic reprints, and miniature models of improvised apparatus may be borrowed from the N.O.P.H.N. for two weeks for use as exhibits. These exhibits will continue to grow as you send new ideas in from the field.

Assistance to the general staff nurse cannot be truly effective without public health nursing supervisors who have special preparation and experience in orthopedic nursing. The N.O.P.H.N. and the National League of Nursing Education have prepared a Tentative

Outline of a Course in Orthopedic Nursing which suggests desirable content in theory and clinical practice for postgraduate courses in orthopedic nursing planned to meet the needs of supervisors in hospitals and in the public health field. Advisory service from the N.O.P.H.N. is available to colleges and universities through correspondence, personal conferences, and the distribution of the tentative outline. The National has drawn up a plan for scholarships to assist nurses in securing preparation in orthopedic nursing. Funds for these have been granted by The National Foundation for Infantile Paralysis. (See page 699 for further details.)

The N.O.P.H.N. recognizes that the educational use of specialized services in orthopedic nursing enriches the generalized service by helping to integrate orthopedic nursing throughout the entire nursing program and by providing an intensive field for observation and practice for students in postgraduate courses. Advisory service to agencies with specialized programs, in regard to content and method of staff education, means of coordinating the general and specialized program, and desirable content of records is available through correspondence and personal conferences. A loan folder on records has been prepared and may be obtained upon request.

Until more well qualified supervisors

can be prepared, the National Organization is giving a limited number of group conferences or institutes on content and methods of staff education in orthopedic nursing. Sponsoring agencies have been state agencies for the care of crippled children and state organizations for public health nursing. The N.O.P.H.N. sponsored such a conference at the Bienial Convention in Philadelphia in May and at the Annual Meeting of the American Public Health Association in Detroit in October.

The advice of our Council on Orthopedic Nursing, comprised of 21 physicians and nurses who are specialists in this field or interested in certain phases of the work, has been invaluable in guiding the development of the orthopedic program. Your N.O.P.H.N. service also needs a constant interchange of ideas from the field if it is to meet your needs. A service cannot grow without constructive criticism. Write to us not only for help but to express your unmet needs and to share your suggestions with others. You can help your National Organization function in a democratic way.

JESSIE L. STEVENSON
Assistant Director

This is the last of a series of articles on the National Organization for Public Health Nursing, written by the president and members of the staff.



NOTES *from the* NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

WITH THE STAFF

Dorothy Deming went to Washington, D.C., on September 16 to attend the Conference of State and Territorial Health Officers. She also made a short field trip to the Middle West before attending the annual meeting of the American Public Health Association in Detroit, Mich., October 5 to 11. She attended the annual meeting of the Macon County Tuberculosis and Visiting Nurse Association in Decatur, Ill., on September 30. From there she went to Burlington, Iowa, and participated in the program of the annual meeting of the Public Health Nursing Section of the Iowa State Association of Registered Nurses on October 3 and 4.

On October 8, Ruth Houlton spoke on "Why an N.O.P.H.N." at the S.O.P.H.N. luncheon and participated in a symposium, "What Nursing Means to the People," at the annual meeting of the State Nurses' Association in Memphis, Tenn.

Evelyn Davis also made a field trip to the Middle West. On October 4, she gave advisory service to the Utica (N.Y.) Visiting Nurse and Child Health Association. From October 5 to 11, she attended the annual meeting of the American Public Health Association in Detroit, Mich. While in Detroit, she spoke on October 10 to the students of Wayne University, her subject being lay community organization. She went to Bay City, Mich., on October 14, to conduct an institute for the board of the Public Health Nursing Service of the Civic League. On the sixteenth, she went to Ann Arbor, Mich., to talk on lay participation to the students of the public health nursing course of the University of Michigan. She arrived in

Neenah, Wisc., on October 18 and conducted an institute for board members of the Neenah-Menasha Visiting Nurse Association and the Oshkosh Visiting Nurse Association. On October 22 she participated in the round table for the lay group during the annual meeting of the Massachusetts S.O.P.H.N. in Boston.

A two-day Statewide Study Program on Nutrition was held under the auspices of the U. S. Children's Bureau in New York City on September 20 and 21. Anna Gring participated in the group discussions on both days. She attended the annual meeting of the American Public Health Association in Detroit, Mich., from October 6 to 10. On October 18 and 19 she was in Clarksburg, W.Va., attending the annual meeting of the State Nurses' Association and speaking at the meeting of the Public Health Nursing Section. She went to Hartford, Conn., on October 25 to attend the luncheon meeting of the School Nurses Division of the State Teachers Association.

Purcelle Peck made a field trip to Nebraska. She participated in a panel on "Health as an Essential Factor in Social Work" at the meeting of the Nebraska Conference of Social Work in Norfolk on October 7. She attended the annual meeting of the Nebraska State Nurses' Association in Omaha, speaking at a luncheon of the Public Health Nursing Section and the State League of Nursing Education on October 8, and on the following day speaking on "The Community We Serve" at the afternoon general session.

A number of orthopedic institutes were conducted by Jessie Stevenson during September and October. She attended the meeting of the U. S. Children's Bureau Special Advisory Com-

mittee on Medical Social Work, Public Health Nursing, and Child Welfare Service in the Crippled Children's Program from September 19 to 21 in Washington, D.C. From there, she went to Asbury Park, N.J., on September 23 to conduct a three-day orthopedic institute under the auspices of the New Jersey S.O.P.H.N. Two orthopedic institutes were conducted by her during the annual meeting of the American Public Health Association in Detroit, Mich., on October 6 and 7. She attended the National Safety Congress in Chicago, Ill., on October 9. She returned to Detroit on the fifteenth to give a two-day institute

under the auspices of the Visiting Nurse Association and the Department of Health, and a day's consultation service to the Visiting Nurse Association. On October 18 she went to Cleveland, Ohio, for a conference concerning the course in orthopedic nursing at Western Reserve University. She returned to New Jersey and conducted two three-day institutes in Camden (October 22-25) and Hackensack (October 29-31), under the auspices of the New Jersey S.O.P.H.N. While in Camden, she went over to Wilkes-Barre on October 24 to attend the meeting of the Pennsylvania S.O.P.H.N.

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Standing Committees

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Claribel A. Wheeler, N.L.N.E.

EXECUTIVE COMMITTEE

(See page 4)

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(See July issue, page 411)

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*Grace Ross, president, and Dorothy Deming, general director, are *ex officio* members of all committees. Purcell Peck, editor of PUBLIC HEALTH NURSING, may attend any meeting of any committee upon request.

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Note: For list of members of Publications Committee see page 2.

ORTHOPEDIC SCHOLARSHIPS FOR NURSES

The National Organization for Public Health Nursing is very happy to announce that The National Foundation for Infantile Paralysis has made a grant to the N.O.P.H.N. for seven scholarships to assist nurses to prepare themselves for orthopedic service.

Scholarships of two types are offered:

Type I

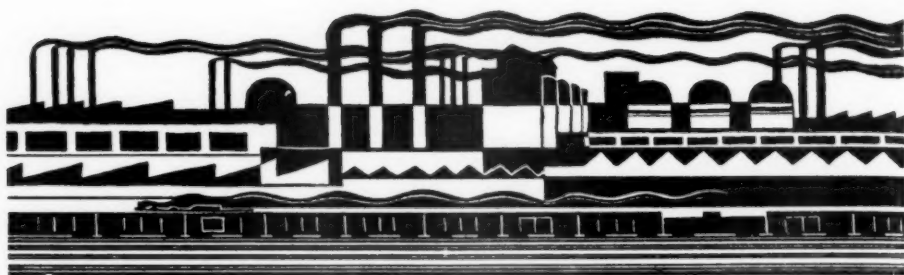
Three scholarships are offered for one year's study to prepare nurses for leading positions as instructors in theory or clinical practice in connection with universities. These scholarships are to be awarded to public health nurses who have had preparation and experience in orthopedic nursing and public health nursing, but who lack the academic requirements to qualify them for teaching positions in universities.

Type II

Four scholarships are offered for one year's study to prepare nurses for positions as orthopedic nursing supervisors in visiting nurse associations. These scholarships are to be awarded to nurses in voluntary public health nursing agencies whose program includes both physical therapy and orthopedic nursing.* The scholarship may be used either for a course in physical therapy approved by the Council on Medical Education and Hospitals of the American Medical Association or for a university program of study in public health nursing approved by the N.O.P.H.N.—depending upon which preparation the nurse needs.

These scholarships are to be administered by the Council on Orthopedic Nursing of the N.O.P.H.N. and a scholarship committee. Further details and application blanks may be obtained by writing to the N.O.P.H.N., 1790 Broadway, New York City.

* The N.O.P.H.N. believes that nurses preparing for supervisory positions in visiting nurse associations whose program includes physical therapy treatment should have preparation in both public health nursing and physical therapy.



HIGHWAY HOSTESSES

A NEW type of industrial nursing service, that of highway hostess, has been inaugurated in the State of Oklahoma according to an article appearing in the July issue of *The Oklahoma Nurse*. The Phillips Petroleum Company has employed 11 graduate nurses to cover the main highways along the routes where its 66 service stations are located. They make sani-

tary inspections of the station rest rooms, consult with the attendants, and make recommendations. They must not only know the needs of travelers but must be able to give information about traffic laws and regulations, places to eat, and the cleanliness and comfort of hotels and camps, and places of interest in the area. Each hostess is furnished with a car and travels alone.

THE INDUSTRIAL NURSE AND THE LABOR UNION

ARE LABOR unions interested in the health of their members? What is the nurse's relation to the union? These questions were discussed at the industrial nursing round table at the Biennial Convention in Philadelphia on May 14, 1940. Various opinions were expressed. Some of the group believed the nurse should not have any tie-up with organized labor. Others thought that a good working relationship with the union to which employees belong is indispensable to giving the best possible service to workers.

Catherine Dempsey of the Simplex Wire and Rubber Company in Cambridge, Massachusetts, pointed out that recommendations for health policies in large companies sometimes originate with the union and that the nurse can often interpret company policies on

health matters to employees through the unions.

Agnes Rabitt, industrial nurse in Anheuser-Busch, Inc., St. Louis, Missouri, said that the unions of employees in her company often have medical programs for which the nurse has suggested speakers.

In connection with this discussion, the announcement by the National Tuberculosis Association of a large-scale tuberculosis survey of workers under the auspices of organized labor is of particular interest. During the past year more than 35,000 New York City workers have been x-rayed by the Department of Health and the WPA. The first survey was among members of the Furriers Joint Council, which requested the study. In less than a year 5000, or

about 25 percent of the union, had taken advantage of the opportunity.

Following this beginning, ten other broad groups of organized labor have applied to the Department for similar surveys—among them the International Ladies Garment Workers Union, the National Maritime Union, and unions of department store workers, pocket-book workers, furniture workers, and food trades. Others are applying for the service.

Employers have given splendid coöperation to the plan and all have granted time off for the x-raying. Usually this has been done at union headquarters or at some place designated by the union.

The cost of the films is paid from WPA funds. The films are read at the Health Department clinic, which sends reports to the employee himself—not to the union or the employer. Each union receives a statistical study covering its members. The health department extends its follow-up service to individual employees who are active cases. While no union has a tuberculosis sanatorium of its own, many contribute to hospitals to which they send members.

This interest on the part of unions in the health of their members shows the possibilities for their coöperation with the nurse in efforts to protect the health of employees.

HAZARDS IN THE SMALL PLANT

MANY IMPORTANT hazards to health of employees which are unspectacular have been overlooked in the attention given to toxic substances which constitute definite occupational hazards, according to an article on "Industrial Hygiene for the Smaller Plant," by Dr. Glenn S. Everts, in the *American Journal of Public Health* for January 1940. Factors which are frequently a contributing factor in lost time include "hazards of extreme dry heat, heat with humidity, sudden variations in temperature, dampness, defective ventilation, defective illumination, and repeated motion."

Dr. Everts also calls attention to the fact that less known toxic hazards are frequently present in small industries but are apt to be overlooked because these plants do not have a full-time industrial

physician especially trained in industrial problems. He suggests that the plant physician go over the various plant processes with the help of the plant chemist or some one well informed, and check this list with scientific data on the effect, of the substances used.

While the study of industrial hazards is primarily the responsibility of the physician, the nurse often plays an important part in bringing to his attention observations that may be significant. This is especially true in the smaller plant where there is no full-time physician and the nurse is the only member of the health personnel in continuous contact with the plant. Industrial nurses in all types of plants will find Dr. Everts' article extremely practical and helpful.



EDITED BY ANNA C. GRING

PRINCIPLES OF ORTHOPEDIC SURGERY

By James Warren Sever, M.D. 418 pp. The Macmillan Company, New York, third edition, 1940. \$3.25.

Dr. Sever has added to this new edition an introductory chapter stressing the importance of the treatment of the orthopedically handicapped person in relation to his role as a useful member of the community. The problems of education, vocational training, and rehabilitation of the crippled child are discussed, and the needs for special classes and schools for seriously handicapped children are outlined. The responsibility of the social service department of the hospital in the care of orthopedic patients is clearly indicated and the relationship of this department to nursing associations evaluated.

As in the last edition, the arrangement and content of the material is excellent. Causes, symptoms, and various types of treatment of orthopedic conditions are clearly and completely explained. Several changes in form have been made and additional orthopedic conditions are included in this new edition. Illustrations are numerous and extremely valuable in clarifying the text.

A separate chapter has been devoted to physical therapy and its use in the treatment of orthopedic conditions.

The third edition of this book continues to be outstanding in its value to

nurses as a text and reference book. It should be useful in the introductory preparation of nurses for orthopedic public health nursing.

ELLEN M. COVELL, R.N.
Astoria, New York

ADVENTURES IN GIVING

By William H. Matthews. 252 pp. Dodd, Mead and Company, New York, 1939. \$2.50.

Adventures in Giving describes the experiences of a man who has known and tried to understand thousands of people in distress. He has believed in them and their capacity to help themselves if given an opportunity and if not forced to submit to conditions which take away the courage and determination of even the strongest to keep struggling. As director of a settlement house, secretary of a committee studying the labor policies and work conditions in steel mills, and director of the Family Welfare Department of the Association for Improving the Condition of the Poor in New York City, the author has tried to keep close to the people whom he was trying to serve, encouraging them to reveal their own struggles and hopes, never judging before he understood, and giving them opportunities to work out their own difficulties. He has been concerned not only with the present but in improving the conditions which would make pos-

sible greater security in the future. The book will be an inspiration and a challenge to anyone who cares about people.

RUTH E. LEWIS
St. Louis, Missouri

THIS QUESTION OF RELIEF

By Maxwell S. Stewart. 32 pp. Public Affairs Committee, Inc., 30 Rockefeller Plaza, New York, 1939 10c.

Almost any public health nurse, no matter how familiar with the subject, can profitably read and use the newly revised pamphlet, *This Question of Relief*, issued by the Public Affairs Committee. Its 32 pages, set in large type and illustrated with pictorial statistics, fit together like a jigsaw puzzle the scores of scattered facts, opinions, prejudices, and fallacies in everyday circulation. What emerges is a picture of our muddled relief policies, national and local, since the depression began, and the direction in which progress must be made toward a better system. Well documented with facts, the pamphlet is clear and vivid in style and sympathetic in treatment.

FLORENCE M. SEDER
New York, New York

A TEXTBOOK OF ORTHOPAEDIC NURSING

By Evelyn C. Pearce. 230 pp. Faber and Faber, Ltd., London, second edition, revised, 1939. \$2.75.

This is a practical volume, well indexed and with an excellent appendix, of particular value to a nurse in the public health field. The author has succeeded in retaining the brevity and simplicity of her first book, and has added excellent illustrations and diagrams. The chapter on anatomy is a good review for anyone. Miss Pearce stresses the importance of body mechanics and how to apply the knowledge of the functioning of the normal body in the treatment of pathological conditions. A good outline for a complete body examination is given in chapter 8.

Although we may not agree with the

author on the treatment of spastics, still it is always well to stress the importance of rhythm and relaxation. We may feel that the chapters on poliomyelitis and tuberculosis are not as valuable as some, but on the other hand the writer's experience with the vast number of rheumatic and tuberculous patients in England has given her the knowledge to write with authority on these subjects.

JESSIE SHAW COMAN, R.N.
Fullerton, California

THE CRIPPLED CHILD IN NEW YORK CITY

Report of the Commission for Study of Crippled Children. 218 pp. The Commission for the Study of Crippled Children, New York City. 1940. Free.

This report includes an analysis of the needs of crippled children in New York City, existing facilities to meet them, and recommendations concerning physical care, education, recreation, vocational guidance, and placement with special attention to social and psychological aspects in all stages of care. Attention is directed particularly to the needs of cerebral palsy patients.

It is recommended that more effective use of existing facilities through integration of all services be accomplished by the establishment of a central coordinating service for crippled children in the Department of Health.

The need for qualified public health nurses is emphasized in order that the entire health, emotional, and social needs of the child may not be obscured by his orthopedic handicap. The means for attaining some of the recommendations do not seem practical. Interchange of information between the public health nurse and the hospital is desirable, but recording of home observations on the hospital record could be performed by a clerk instead of the public health nursing supervisor. It also seems more logical that instead of the supervisor the staff nurse should discuss problems concerning her own patients

with the social service department. Although the orthopedic nurse in an active treatment service could give health supervision to the family of the crippled child, only on a selective basis could she give bedside care for other illnesses without sacrificing the needs of other orthopedic patients.

This report will prove useful to all agencies interested in any phase of the care of crippled children.

J. L. S.

INDUSTRIAL HYGIENE

Edited by A. J. Lanza, M.D., and Jacob A. Goldberg, Ph.D. 743 pp. Oxford University Press, New York, 1939. \$8.50.

In this book, the authors have presented for the consideration of industrial physicians those phases of medicine and hygiene which especially concern them. The chapters, each written by specialists, cover a wide range of subjects including the organization of industrial health service, physical examinations, tuberculosis, heart diseases, mental hygiene, various industrial dust, gas, and fume hazards, lighting and atmospheric control, and health education of the worker. There is a chapter on the nurse in industry by Rosamond W. Goldberg.

Industrial nurses will find this book a valuable ready reference on industrial hygiene. The book is well indexed, and as a further reference aid a selected bibliography is included at the end of each chapter.

E. G. MEITER, PH.D.
Milwaukee, Wisconsin

INDUSTRIAL HEALTH—ASSET OR LIABILITY

By C. O. Sappington, M.D. 273 pp. H. M. Van Hoesen, Jr., Inc., 30 North LaSalle Street, Chicago, 1939. \$3.75.

This monograph is addressed to professional and lay groups interested in adequate health services for small as well as large industrial plants. The author presents in an engaging and pre-

cise way the fundamental principles of health promotion work in industrial and commercial establishments and illustrates by comparison how a health service may be either an asset or liability. The contents include an appendix on examination and industrial survey forms.

The chapter on the industrial nurse, outlining her functions in industry and her qualifications essential for success—physical, personal, and professional—should be helpful to the nurse either contemplating or engaged in service of this type. Other sections that will appeal to the nurse deal with the fundamentals of an ideal plant health service, the philosophy of health, and community relationships.

It is to be regretted that the one really technical chapter on special problems—fatigue, posture, noise, nutrition, mental hygiene, absenteeism, recreation, ventilation, and illumination—is not more specific. This does not, however, seriously militate against the value of the book, which is replete with information useful to those responsible for the promotion of health services in industry.

WILLIAM MCCONNELL, M.D.
New York, New York

SILICOSIS AND ASBESTOSIS

Edited by A. J. Lanza, M.D. 431 pp. Oxford University Press, New York, 1939. \$4.25.

This volume is a compilation by both English and American authors and represents the first concerted effort to bring together the knowledge of this subject in an organized fashion for those who need authoritative material. The book includes chapters on the history, etiology, symptoms, diagnosis, and pathology of silicosis in addition to a valuable bibliography on Roentgen-ray diagnosis. There is also a short chapter on the public health and economic aspects of these diseases in the United States.

Some criticism has been made of the

spacing of the table of contents and the lack of an author's index. In spite of these mechanical defects, which are after all a minor consideration, the material of the book stands as the best that has ever been gathered. The volume should be of definite assistance for many years to come, to those who must know and appreciate the difficulties which have heretofore been experienced with these diseases in their many complicated interrelationships.

C. O. SAPPINGTON, M.D.
Chicago, Illinois

TREATMENT BY DIET

By Clifford J. Barborka, M.D. 691 pp. J. B. Lippincott Company, Philadelphia, fourth edition revised, 1939. \$5.

This is the usual type of book written on the subject of the dietary treatment of disease. Separate diets are given for a large number of diseases. Practically every type of diet necessary for the dietary treatment of disease is illustrated. In the section on diabetes the carbohydrate contents of the diets given only go as high as 180 grams. In view of the fact that in the more recent treatment of diabetes much higher carbohydrate diets are used, it seems too bad that such diets were not included in this chapter.

There is one chapter in which the principles of nutrition are discussed. The book would serve as a practical reference book for anyone requiring to use diet as a therapeutic measure. Unfortunately the carbohydrate, protein, and fat values of the foods are not shown in the diet menus, leaving the reader to calculate these for himself.

ELAINE P. RALLI, M.D.
New York, New York

YOUR CHILD'S FOOD

By Miriam E. Lawenberg. 299 pp. Whittlesey House, New York, 1939. \$2.50.

This book is an excellent one of its type. It will be of special value to the

doctor, nurse, nutritionist, teacher, or nursery school worker who works with or gives advice concerning young children, because of its sane, practical suggestions relative to all phases of the child's food, food habits, and food preparation. Most of these are not new but all are sound and very well discussed.

Parents also will do well to read the book but may find it easier to understand than to apply. Certainly, the latter part of the book which deals with menus and recipes will be of distinct value to mothers. A good dinner menu is given for every day of the year (what a boon for an interested, persevering, but very busy mother!). The recipes for all kinds of nutritious dishes are interesting to read, apparently simple to prepare, and sound palatable and less "dietetic" than many that drop from the pen of specialists.

The readers should be reminded that in addition to reading this excellent book on the subject of the child's food, they should study all the *other* phases of hygiene which contribute to his health.

EMILY P. BACON, M.D.
Philadelphia, Pennsylvania

SIMPLIFIED DIABETIC MANUAL

By Abraham Rudy, M.D. 216 pp. M. Barrows and Company, New York, 1940. \$2.

The part of this book which recommends itself especially is that containing food recipes for various nationalities based upon their native food habits. This section includes recipes for Jewish, Swedish, Italian, Armenian, Greek, and German groups.

As a whole the language of the book is too technical for the average layman; yet the text is too sketchy for the professional reader. Some statements are made which are questionable in their accuracy. For example, on page 25 the statement is made that "Vitamin A deficiency can develop in diabetics on a low fat diet." Yet, elsewhere the author

shows that one serving of spinach will supply more than adequate amounts of Vitamin A for the patient.

The book probably has most value

for those who work with various national groups in this country.

HERBERT POLLACK, M.D.
New York, New York

RECENT PUBLICATIONS AND CURRENT PERIODICALS

ORTHOPEDIC NURSING

CASE WORK WITH CRIPPLED CHILDREN. Georgia Ball. *The Family*, April 1939, p. 56. Family Welfare Association of America, 122 East 22 Street, New York.

This discussion of psychological and social problems arising in connection with the handicapped child should be a "must" on the reading list of every public health nurse.

THE FAMILY HELPS THE SPASTIC CHILD. Belle McKinnon. *Hygeia*, August 1939, p. 725.

This remarkable story of how the parents of a spastic child helped her to achieve a happy, well rounded life in spite of her handicap contains many specific suggestions for the development of physical and emotional health, and social adjustment.

FUNCTIONAL DISORDERS OF THE FOOT. Frank D. Dickson, M.D., and Rex L. Diveley, M.D. 305 pp. J. B. Lippincott Company, Philadelphia, 1939. \$5.

Although written primarily for physicians this book is useful for nurses employed in orthopedic programs.

NURSING CARE FOR THE SPASTIC CHILD. Margaret M. Gorey, R.N. *The American Journal of Nursing*, April 1939, p. 367.

Suggestions in regard to the nurse's contribution to the treatment and education of the spastic.

UNDERSTANDING AND GUIDING THE SPASTIC. Earl R. Carlson, M.D. *The American Journal of Nursing*, April 1939, p. 356.

A practical discussion of effective methods of treatment and rehabilitation for this most neglected group of handicapped children.

WHAT DO WE OWE THE CRIPPLED CHILD? Samuel E. Kohn, M.D. *The Physiotherapy Review*, March-April (published bi-monthly), 1938, p. 73.

FACTS ABOUT CRIPPLED CHILDREN. Children's Bureau, U. S. Department of Labor, Washington, D. C., March 1940. 15pp. Free.

This 15-page pamphlet presents in concise form significant facts gleaned from the registers of state agencies administering programs for crippled children. Included in it are:

number of crippled children on state registers, causes of crippling, progress in provision for care and treatment, method of administering services, program of services offered by states, funds allocated to each state, suggestions concerning prevention, and methods of coöperation of public and private agencies. The names of the state agencies administering services for crippled children are listed.

THE IMMIGRANT IN AMERICA

IMMIGRATION AND THE NATIONAL WELFARE. Felix S. Cohen. 40pp. League for Industrial Democracy, 112 East 19 Street, New York. 15c.

AMERICANS IN THE MAKING. William C. Smith. 454 pp. D. Appleton-Century Company, New York, 1939. \$3.75.

IMMIGRANT GIFTS TO AMERICAN LIFE. Allen H. Eaton. 185pp. Russell Sage Foundation, 130 East 22 Street, New York, 1939. \$3.

OUR RACIAL AND NATIONAL MINORITIES. Edited by Francis J. Brown and Joseph S. Roucek. 877pp. Prentice-Hall, New York, 1937. \$5.

THE YOUNGEST PIONEERS. Marian G. Greenberg. *Survey Graphic*, March 1940.

PIONEERS FROM THE NORTHLAND. (Finns) Z. G. Hawley. *Christian Science Monitor*, Weekly Magazine Section, June 29, 1938.

AMERICANS ALL. (Poles) W. Seabrook. *American Magazine*, August 1937, p.48.

THE INDUSTRIAL PSYCHOLOGY OF THE IMMIGRANT MEXICAN. Thomas R. Garth. *Industrial Psychology*, March 1926, p.183.

THE PSYCHOLOGY OF THE REFUGEE. Gerhart Saenger. 10pp. Reprinted from *Contemporary Jewish Record*. American Jewish Committee, 386 Fourth Avenue, New York. Free.

REFUGEE FACTS. A Study of the German Refugees in America. 24pp. American Friends Service Committee, 20 South 12 Street, Philadelphia, 1939. Free.

AMERICA AND THE REFUGEES. Thomas Mann. *New Republic*, November 8, 1939, p.38.

OPEN OUR DOORS TO REFUGEES. *Readers Digest*, May 1939, p.82.

A MANUAL OF INFORMATION FOR ALIENS AND THOSE ADVISING THEM. (Alien registration) 64pp. Common Council for American Unity, 222 Fourth Avenue, New York. 15c.

NEWS NOTES

- An epidemic hospital and mobile unit to study wartime diseases is to be established in England by the American Red Cross and Harvard University. The 100-bed hospital, to be known as the American Red Cross—Harvard Hospital, will be constructed and financed by the Red Cross and will be used for the study and treatment of communicable diseases under wartime conditions. Harvard University will furnish the medical staff and assume responsibility for the scientific work. The University has already formed a new Harvard Public Health Unit for field and laboratory work in epidemiology in Great Britain. The unit and the hospital will work closely together. It is believed that not only will this undertaking present an unusual opportunity for humanitarian service but the staff will be in a position to acquire information on problems of public health under conditions of modern warfare which may be of great value in the event of defense or other emergencies such as disasters in this country.

Dr. John E. Gordon, professor of preventive medicine and epidemiology in the Harvard Medical School and a recognized leader in this phase of public health work, will head the project. (See page 651.)

Patience L. Clarke has been appointed chief nurse of the hospital and Gertrude Madley will be assistant chief nurse. Both women are now connected with the Herman Kiefer Hospital in Detroit, Mich.

- A two-reel sound film on cancer, "Choose to Live," has been released by the United States Public Health Service. This movie, based on the story of one woman's encounter with cancer, was prepared for lay audiences. The actors in the film are professionals, and the laboratory and hospital scenes were taken with scrupulous attention to med-

ical accuracy. The running time of the film is 18 minutes. It is available for short time loans from the Division of Sanitary Reports and Statistics, United States Public Health Service, Washington, D. C., in either 16 or 35 mm. for the cost of transportation both ways.

- American Education Week will be observed from November 10 to 16. The general theme will be "Education for the Common Defense." The National Education Association, 1201 Sixteenth Street, N.W., Washington, D.C., has prepared materials which are available at low-cost prices to assist schools and communities in the observance of this week.

- The public health nursing curriculum in the Department of Hygiene at the University of California presented for its summer session a three-weeks' institute on Maternal and Infant Hygiene. The enthusiastic response from 65 registered nurses, representing 5 states and the Territory of Hawaii, is evidence that the course was successful. Louise Zetzsche, supervisor of the maternal program of the Denver Visiting Nurse Association, was guest instructor.

- A grant of \$5000 has been made by the American Red Cross for the survey of national nursing resources in the United States to be made by the Nursing Council on National Defense, (see September issue, page 579), with the co-sponsorship of the United States Public Health Service. The grant from the Red Cross will be used to provide a statistical worker and a clerk-typist to supervise the collection and analysis of the data secured through the survey. Workers from the Works Progress Administration will compile the questionnaires received.

A SYMPOSIUM ON ADOLESCENCE

Newer Knowledge of Adolescents Essential for School Health Workers

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THE APPROACH of this Christmas season finds the entire world in the shadow of devastation and suffering such as it has not known for centuries. War, which has always been the ultimate evil in human existence,

has evolved from a conflict between armed forces to a wholesale destruction of noncombatants, the old and the young, the weak and the strong together. In every country touched by the conflict there is widespread suffering of those who had no part in the making of this war. The future cannot be foreseen; but it is apparent that profound social changes are occurring which are building a different world than that which we have known.

Thoughtful people realize that the underlying causes of this conflict go far deeper than surface manifestations would indicate. Many students of contemporary history are endeavoring to analyze these fundamental causes in the hope of dispelling some of the confusion of these days. One such writer in the November issue of *Harpers Magazine* finds the answer in the failure of society to meet the "new and quite unpredictable needs" growing out of "the intolerable strains of modern civilization." He suggests that "we are enduring not the second but the twenty-seventh year of this war," which is really a continuation of the struggle that has

been present in some part of the world since it began in 1914, and which has its roots in "the failure of statecraft, economic as well as political, to operate the machinery of the new industrial civilization in such a way as to make the lives of the masses of the people at least endurable."* He emphasizes the inescapable necessity of solving our own social and economic problems if we are to have a democracy with assurance of inner strength.

The solution of these problems as they relate to the life and health of mothers and babies was the subject of an all-day session of the National Council for Mothers and Babies in Washington, D.C., on November 18—a Council composed of 60 national lay and professional organizations concerned with this question which is basic to the well-being of our people. "Equality of opportunity" as a source of national strength was the keynote stressed by Dr. Fred L. Adair of Chicago in tying the aims of the Council to the vital needs of the country in these times of national anxiety.

A graphic interpretation of this, our basic problem, is found in the message of Harriet Elliott, consumer commissioner, National Defense Advisory Commission, in her introduction to a special issue of the *Consumers Guide*** which dramatically portrays through il-

*Johnson, Gerald W. "To Our Thirty-Year Olds." *Harpers Magazine*, November 1940.

***Consumers Guide*. Department of Agriculture, Washington, D.C., September 1940.

lustrations and descriptive legends the necessity of building a society strong from within because it meets the basic, human needs of all the people:

"We are rich in people. People who love and cherish our lands. People who know how and want to work. People who have deep faith that here we have the greatest chance for life, and liberty, and the pursuit of happiness. People who know the fight for these is never won until it is won *for everybody*." [Italics ours.]

At this Christmas time let us dedicate ourselves anew to our task of fulfilling the responsibility which Miss Elliott so well defines, to "make every American strong, stronger than ever before, sturdier in body, steadier in nerves, surer in living"; and our task of service in the larger sense, to work unceasingly as citizens toward the building of a more generous society out of the chaos of these times—a society that will be strong from within.

P. P.

PROTECT OUR HOMES FROM TUBERCULOSIS

CHRISTMAS SEALS



Help to Protect
Your Home from
Tuberculosis

WE KNOW that the tubercle bacillus can best be thwarted in its development when it is discovered early in its career. If, therefore, we are to realize our goal of the eradication of tuberculosis by 1960, persistent efforts to find all persons with early tuberculosis

must continue. This dread disease continues to be the leading cause of death among young people in the age group between 15 and 35 years.

Because tuberculosis is so insidious in its attack and the symptoms are so delayed, we are considerably hampered in trying to discover cases in time to protect contacts from the disease. But the public health nurses in the homes, in the schools, and in industry, and indeed all nurses, are in strategic positions to participate in the tremendous job of finding those individuals with early signs of tuberculosis.

Though case-finding is the essential first step in this fight, the next step is as imperative. For the discovered, uncared-for individual with tuberculosis

continues to be a menace to himself, his family, and society. We as nurses must teach the patient so effectively that he will participate eagerly in those plans which will hasten his return to normal, everyday living. The challenge to those of us who are board and committee members is equally as great. It is our responsibility to participate in the type of community planning which will provide the resources essential to finding, treating, and curing tuberculosis.

A valuable addition to the materials for community education on tuberculosis is "Goodbye, Mr. Germ," an extraordinary motion picture* with sound, just released by the National Tuberculosis Association.

We are sure that the challenge to protect our homes from tuberculosis will not find us wanting, and that all of us, nurses and laymen alike, will combine our efforts by buying and using the Christmas Seals, through which national, state, and local tuberculosis associations are enabled to continue their attack on the tubercle bacillus.

*Information about this film (16 mm. and 35 mm., 14 minutes) can be obtained from state and local tuberculosis associations or from the National Tuberculosis Association, 1790 Broadway, New York City.

Rheumatic Heart Disease in Children

By MELVILLE A. GOLDSMITH, M.D.

Children with rheumatic fever should have absolute rest and skilled nursing care, a strict regimen during convalescence, and follow-up supervision to prevent recurrence

RHEUMATISM in acute and chronic forms has been described in literature since the seventeenth century, but it was not until the latter part of the eighteenth century that the relation to heart disease was first pointed out.

It was recognized that this disease was most often seen in childhood, and that it involved the joints and fibrous tissues of the body, such as tendons and periosteum; the brain, in certain cases; and the heart, in the form of endocarditis, myocarditis, and pericarditis. The relation of rheumatism and chorea was not noted until about the middle of the nineteenth century.

ETIOLOGY

The etiology as to the organism causing the infection is still in doubt. Theories as to filtrable virus, streptococci, and other causative organisms are still unproven. It seems rather certain that there are many predisposing factors having to do with the development of the rheumatic infection in children. Climate seems to have an important bearing. It has been observed for years that rheumatism in the form of acute rheumatic fever is a disease of the colder, damper climates. The rheumatic infection is also a disease of the lower economic group, being rare among the well-to-do classes. Heredity, or at least a family predisposition, is an important factor. The disease seems to attack certain families in which several members have developed the condition, with perhaps a father

or mother who had the rheumatic infection in early life.

Poor housing and concomitant social conditions also seem to be predisposing factors. Crowded living quarters, poor ventilation, lack of sunshine, dampness, crowded sleeping quarters, poor hygiene, and poorly balanced diets with insufficient quantities of food to insure proper growth and development are among the things noted in the social histories of these rheumatic individuals.

Seasons of the year seem to play a part. Most of the cases of rheumatic fever in the United States occur in the early spring and summer, from February to May, while in England the fall and winter are the two seasons when most of the cases occur.

Recurrent attacks of rheumatic fever in our children's clinics seem to follow acute infections, such as acute colds and sore throats. These usually follow exposure to cold, wet weather, and the usual chilling from damp clothing and wet feet. All of these predisposing causes are important from a nursing standpoint and it is here that the advice of the public health nurse in regard to the prevention and proper care of acute respiratory infections is most valuable.

HEART COMPLICATIONS

It is safe to say that nearly 75 percent of all children having rheumatic fever develop some form of heart complication. This is usually in the form of endocarditis causing a valvulitis. The valve most commonly involved is the mitral valve and the next most common

is the aortic valve. These valves may be attacked individually or both may be involved together. The tricuspid and pulmonary valves are seldom affected. Perhaps there is always some myocardial involvement and very often there are some pericardial changes as well.

The pathology is usually found at the edges of the valves, resulting in thickening and deformity and also a gluing together at the lateral edges, progressing to a narrowing of the opening. This process is progressive, causing an insufficient valve and eventually a stenosis, and is in general the same in both the mitral and aortic valves. There seems to be no medicine that is of much value in slowing up this process of valve change. More important is building up in the patient a resistance to the infection that seems at least to slow up the development of the valve lesions. This is accomplished in the acute stage by absolute rest, good nourishing food, careful nursing until the patient is normal clinically, and continuance of treatment until all of the laboratory findings, such as blood count, blood sedimentation rate, and electrocardiograms, are normal. This convalescent period may take several weeks or months before the patient is back to normal well-being and weight, and the regimen of care should be strictly carried out. After this period of careful watching, the patient is gradually allowed to get back to normal living.

At St. Christopher's Hospital for Children, in Philadelphia, for the past seven years we have insisted that as soon as the patients are back to normal they begin to live a normal life, doing all the things that a normal child does, except extremely competitive games. This program is carried out regardless of the type of valvular lesion, provided there is no functional disability. We find that by such a program stronger, more normal individuals are developed with a better myocardium which will be able

to carry on longer under any type of valvular handicap. At the same time, a better mental attitude is developed, both in parents and children.

While every child with a cold, sore throat, grippe, or any other respiratory infection should receive special care, such care is particularly important in the case of a rheumatic fever child. He should be put to bed; the family physician should be called; and arrangements should be made for carrying out the doctor's orders as to diet, fluid intake, and medication. The child should be kept in bed until the attack is over.

A follow-up of these patients is important. They should always be watched for any changes in the heart condition, or any new developments that might lead to another attack of rheumatism and thus to more heart damage. Parents are carefully instructed about the child's condition and about the many predisposing factors—especially infections of the upper respiratory tract. This instruction is also carried into the homes by the social service workers and the public health nurses, who from time to time are sent to visit the families. Some patients are seen in the clinic each month, some every three months, and many, with little heart damage, every six months.

CHILDREN WITH CHOREA

This same general program is also carried out in the cases of heart disease following chorea. In general, about one half of all chorea patients develop some heart disease, usually involving the mitral valve. In these cases, the most important factor in causing recurrent attacks of chorea is anything that disturbs the child emotionally, such as returning to school with work to be made up, and the nervous tension of class work and problems requiring close concentration. We find many recurrences of chorea with the possibility of more heart damage following the child's return to

school. Children who have been well and free from symptoms for months will show symptoms within the first month after school opens in the fall. Of course other things, such as unsatisfactory home conditions, or trouble of any kind that puts extra stress and strain on the nervous system will have the same bearing on recurrent attacks.

Usually there is a rather characteristic story from the parents. They have noticed a change in the disposition of the child. He has become irritable and peevish, weeps easily, and is always in trouble at play. His school work has become poor, and reports from his teachers say that he is inattentive and not interested. These are symptoms that appear long before any muscle activity is noted and are important to recognize so that rest and treatment may be started at once, to avoid, if possible, any further progress in the heart disease which may have been started by previous attacks.

As far as the heart condition itself is concerned, the treatment is the same whether the rheumatic infection causing it was manifest as acute rheumatic fever or chorea. Rest, good food, nursing care, and hygiene are the important features. In the recurrent attacks of rheumatic fever, some form of salicylate medication is used; while in the recurrent chorea cases, sedation is important, usually in the form of phenobarbital in doses sufficient to control the nervous-

ness. In childhood, the heart conditions are discovered and watched from the very beginning of the disease. Nursing care and advice are important and helpful in checking the progress of the disease—or at least in slowing it up.

Other conditions of rheumatic heart disease, such as acute myocarditis, acute pericarditis, and adhesive pericarditis are not discussed in this article, because patients with these conditions are usually seriously ill in the hospital. They are oftentimes terminal cases, and their care is not the immediate responsibility of the public health nurse. Likewise, patients with severe endocarditis who develop auricular fibrillation with congestive failure are hospital cases, usually the end result of several previous attacks of endocarditis. From the standpoint of preventive medicine, the problem is to prevent patients from getting to this severe terminal stage if possible. However, if the condition does appear, rest, skilled nursing care, and medication as indicated comprise the general treatment; and if the patient survives the attack, a very careful, restricted life is necessary. Fortunately, the children who develop these conditions are very few.

This is the second of a series of articles by Dr. Goldsmith on various types of heart disease and the part of the public health nurse in its control. The next article will discuss various forms of heart disease in adults.

HAPPY DAYS ARE HERE AGAIN

Moving is over. Packing boxes are a thing of the past. On every side we hear, "Oh, I like it here." We were a little concerned at first lest our N.O.P.H.N. members would find it inconvenient to visit us in our new quarters but it seems to have made no difference. Even a

member from Honolulu dropped in the other day! Won't you come the next time you are in New York? A hearty welcome awaits you at our new office on the tenth floor of 1790 Broadway. Or is it easier to remember the corner of Fifty-eighth Street and Broadway?

What Is Good Postpartum Care?

By MAE D. McCORKLE, R.N.

Present emphasis on continuous and adequate care throughout the maternity cycle calls for a reconsideration of needs during the often neglected postpartum period

ANTEPARTUM, intrapartum, postpartum—all these are phases of one continuous maternity experience for the mother and infant, for the family, and also for the community. No matter how we may divide the maternity cycle for convenience in discussion, it is important that we do not lose sight of its essential unity in relation to the mother's experiences and the interrelationships between mother and child.

On the assumption that mother and baby have come through the antepartum and intrapartum phases alive and in normal condition, these are suggested as goals for the postpartum period:

1. A mother who progresses to normal strength and resumption of activities, ready to make the new adjustments required.
2. A mother happy in the outcome of this particular experience in child-bearing, accepting motherhood in a matter-of-fact kind of way.
3. A mother who continues to fulfill her function in nourishing and caring for her infant; who knows how to take over his care, and where and how to get advice and help when needed.

Into the successful achievement of these goals must go a combination of educational, social, economic, medical, and nursing factors, no one of which can produce the desired result alone. Also, in the consideration of maternity care we must take account of the changing concepts of the age we live in. We have become conscious of new needs and new horizons. Hence, as we have seen, the achievement of former goals—goals that

were set up when the emphasis was on antepartum care, when there was not the same demand for wage-earning by women, when there were not the many factors diverting a woman's attention from the performance of her normal biologic functions—we have found new motivations. Moreover, as our concept of maternity nursing enlarges and we improve our preparation for it, we get new visions of what the nurse can help accomplish in the care of mothers and babies.

For instance, physical health following childbearing is undoubtedly better than it once was. Gynecological wards are today less filled with patients who are there for repair of conditions resulting from childbirth. But the beds are still full of patients with other types of conditions which suggest new directions for our program—as for example, cancer and abortion. The problem of cancer of the reproductive organs, the most common form of malignancy in women, fits in with a program for nursing follow-up to help assure medical supervision in the postpartum period. The problem of abortion belongs largely to preconceptional education and antepartum management of the maternity situation; but not entirely. Is it not our inclination to dismiss a case of abortion with less postpartum supervision than usual? Do we recognize in it an organism depleted and shocked physically and emotionally, requiring a regimen for restoration to normal health at least as important as if the pregnancy had gone to completion?

MENTAL HEALTH OF MOTHERS

Although physical health of the child-bearing woman is probably better today than formerly, I do not believe this is equally true of mental and emotional health. How much do we know about what is happening to patients mentally and emotionally after the birth of their babies? Do we see them often enough to know? Would we be better prepared to know, if nurses were present at more deliveries? Since mental breaks associated with childbearing so often appear after the six- to eight-weeks' postpartum period, do we have a method of keeping in touch with the mother through child health supervision or some other service so that we know what the outcome is? The campaigns of the past five years have done much to reduce maternal deaths. What about the tragedies in regard to happiness and emotional health? Surely no one is better able to make pertinent observations and to assist the physician in getting recommendations carried out than the nurse who sees the patient in her home environment.

CARE DURING THE LYING-IN PERIOD

Whether childbirth occurs at home or in the hospital, what are some of the responsibilities of the nursing service during the lying-in period? I shall not include technique in breast care and perineal care and related nursing procedures, although the nurse's part in increasing comfort and relaxation, and preventing infection and complications, is an important one. Let us list a few of her other functions:

1. To direct care to the accomplishment of normal involution, and to teach the mother points that concern care which is to be continued after her return home—such as postpartum exercises, and hygiene relating to rest, diet, and her regimen of living.
2. To help establish breast feeding successfully.
3. To teach the mother the essentials that help maintain a supply of breast milk.
4. To teach the mother, if she is a primipara, two or three ways of holding her baby. Recently the nurse found a mother home from the hospital who had not taken her baby from its bed for three days, so fearful was she of handling him. The fear experienced by new mothers when they are confronted with their own limp offspring is unbelievable except by those of us who see it so frequently in the homes. In mothers' and fathers' classes inexperienced parents often ask, "How do you pick up the baby? How do you hold him?" This illustrates the small but important things that call for help, and which may require frequent visits to get a mother and baby under way successfully. Such a detail is also tied up with success or failure in breast feeding, to mention only one important outcome.
5. To teach the mother how to bathe and dress her baby. No new mother should be left to the care of her infant until she has changed the diaper at least once on her own child.
6. To teach her before leaving the hospital how to make and care for a formula if the baby is on one—unless this can be promptly handled by a visiting nurse service that takes over supervision in the home.
7. To be acquainted with the home conditions to which the mother and baby will return when they leave the hospital. No hospital nurse can do an adequate piece of maternity nursing with teaching unless she consciously recognizes this factor, even though immediate responsibility for the matter may rest in the hands of the social service or some other administrative department. Even such knowledge about the home as the nurse gleans from conversation with the patient should make the instruction offered the mother much more applicable.
8. To see that the mother and new

baby are discharged to other nursing service when they leave the hospital. Who more than the nurse in the hospital should be expected to appreciate this mother's need for guidance after she gets home? Yet because so few hospital nurses have had opportunity to see what the return home means to mother, baby, and family, far too few are instrumental in effecting this tie-up.

9. To be sure that the mother has a return appointment for a postpartum medical examination, understands the reasons for it, and is encouraged to keep it.

10. In the case of a home delivery, to see that nursing care in the home is provided. This varies from care given by a private, graduate nurse, duplicating the fine, continuous nursing service of a good hospital, to the amount that can be given in one or two hours of the visiting nurse's time, with or without proper care by a relative or neighbor during the remainder of the twenty-four hours.

What constitutes adequate postpartum nursing care during the lying-in period? It has been described by various authorities such as Dr. Fred Adair in his little book on *Maternal Care*.^{*} A common answer is, "Care which meets the needs of the situation." Of course, it has to be that, but if we just left it there we wouldn't be helped very much, would we?

The first eight to twelve days determine many things for the mother and baby. The most important stages of breast and pelvic physiology have to be dealt with in this interim. Also, all the infant's new physiologic functions of breathing, feeding, and eliminating are established now, as well as the emotional adjustments of the mother and the family to the new member. Child guidance today is teaching us much

about behavior and its relationship to the experiences of infancy and early childhood.

The complex circumstances which we often see leading to rejection of the infant before birth are frequently carried over after birth. Everything that causes the mother nervous strain while she is still physically incapacitated and emotionally unstable, every situation that tempts her to get up and about in hopes of solving the problem at hand will, even if it does not lead to physical impairment or actual emotional crises, result in helping to make her rebellious against having more children. The steadying hand and head of the understanding nurse can do much to make this adjustment a happier one for all concerned—mother, infant, and family.

HOW FREQUENT SHALL VISITS BE?

How frequently, then, shall nursing visits be made during the postpartum period? This question takes on a practical character today when economic stress cries, "Cut down." Care of a maternity patient always has called for a larger number of hours per patient than that of any other type of case. Isn't the event of getting a new human being ushered into the world and established here worth it? With all the years that hospitals have been nursing maternity patients, they have never yet given full recognition to this fact, so one is not surprised to meet the lack of it in home care. Considering the amount of nursing service the patient would have had in the hospital, considering the amount we would want for ourself, our sister, or best friend—is a daily call of one to two hours out of twenty-four too much for expert care and supervision?

Considering the crises that can arise in connection with breast-feeding, the weakened condition of the mother, and the emotional strains that can appear from loss of sleep, lack of strength, being unready to accept the infant, the tempta-

^{*}Adair, Fred (editor). *Maternal Care*. University of Chicago Press, Chicago, 1937.

tion to do indiscreet things when supervision is relaxed—how can any nurse attempt to assume responsibility for adequate care and supervision without seeing the patient at least daily until she is up and around? Leaving a mother to herself with the uncertainties that arise when breasts behave in unfamiliar ways, when pelvic symptoms new to the patient occur, when respiratory difficulties and rashes and discharges may appear in the infant is apt to cause her to say "Never again."

One of the main questions is: "What is this mother's rebound? How does she react to the experience she has just come through?" It is subsequent efficiency of motherhood we are concerned about, quite as much as vital statistics. Society cannot afford to say to a woman, "You can have so much care and no more because you cannot pay." It must prove by the kind of care it makes available that it considers the vital resources which reside in human beings important.

How much visiting shall the nurse do after the mother is up and taking over care of her baby? Whoever said in the first place, "Once a week until six weeks postpartum"? Surely no one ever meant that! "Until the six weeks postpartum examination is made and the mother and baby are sailing along well on their own," comes nearer to being what was meant. Watch the records of the public health nurses whom you rate as doing good maternity nursing because they evaluate needs found and services given, as they go. Do you not find that this six weeks invariably runs into eight weeks simply because adequate supervision cannot be rounded out in less time if any problems at all have arisen? It is preferable moreover that the mother and baby be supervised as a unit throughout the period by the same staff of nurses instead of turning the baby over to a different group in the community at two to four weeks of age. The program which separates care divides

into two parts that which is better treated as a unit, on account of the physiologic and emotional bonds that exist between mother and child.

PERIOD OF GREATEST NEED

The period of greatest slump for the mother is the first two or three weeks after return from the hospital; or, if baby is born at home, after getting up. There is no period in the entire maternity cycle in which the nurse can be of greater service, and in which she has failed more often. This is due in part to the policy of her organization which often calls for one visit a week or less, and partly because she does not sense the need. But unless the nurse is getting in to fit her teaching to the home situation, even to the point of finding a way of getting extra help for the mother, it will not take on much meaning.

If the mother has left the hospital nursing her baby, it is in this period after the return home that she is most apt to meet discouragement. Because she does not know how to meet the situation when a fretful baby and a diminished milk supply appear simultaneously, she solves her problem by putting the baby on the bottle. In the majority of instances this develops into the permanent use of the bottle when with more help it might have been no bottle at all or a bottle only temporarily. In most cases the mother has no knowledge of the values of breast feeding for herself and the baby, but she is apt to respond when taught its advantages physically and emotionally for both of them.

Perhaps the fact that the breast milk so often fails at the second or third week postpartum is one reason for the practice of getting the baby to the physician or child health conference at the end of its first four weeks. Is this not another instance where in separating the care of the mother from that of the baby we have forgotten the physiologic needs of

the mother? Ought any mother to be pushing a perambulator or carrying a baby up and down stairs at four weeks after delivery? Would it not be better to have a system of more intensive home visiting by nurses working in close coöperation with medical authorities and well prepared to assist in the supervising and the feeding of infants?

HOUSEKEEPING AID IMPERATIVE

If society wants women to bear children willingly, it must not only provide security regarding food, clothing, and shelter, but also more housekeeping assistance following childbirth until mothers have regained their strength. Large numbers of our poor mothers (and approximately half the babies are born into homes with incomes of \$1000 or less*) have little hope for reasonably adequate care so long as there is no one to cook, clean, launder, run after young children, and give the mother a respite while she takes rest for sleep lost at night and regains her energies. The nurse of all people has the best opportunity to witness the deleterious effects of this hardship and therefore has the responsibility for becoming vocal about it. Existing housekeeping services under private sponsorship and under projects of the Works Progress Administration are a beginning in recognition of this need. Surely it is not too much to suggest that this country follow the example of New Zealand which includes in its interpretation of adequate postpartum care, housekeeping assistance for enough

weeks following childbirth to put the mother securely on her feet, including the successful establishment of breast feeding.

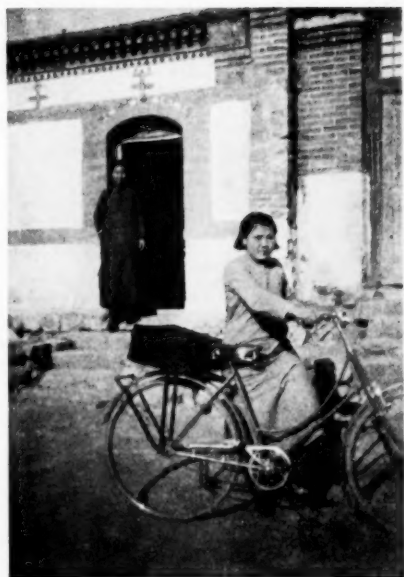
A great deal is said today about more nursing care for chronic illness and for acute communicable diseases, with the implication that these refer to something apart from the maternity service. At the same time it is suggested that in order to give these services we shall have to give less time to maternity nursing.

Let us keep in mind the potentialities of the maternity service in prevention of these other two classifications of disease. Cancer and mental illness have already been mentioned as complications related to childbearing. In their chronic form these complications involve heavy costs. Can prevention through adequate postpartum nursing care have any effect in lessening acute communicable diseases? We know one point at which it can, anyway. Studies* indicate that in the first year of life there are fewer breast fed babies than artificially fed babies who have upper respiratory and gastrointestinal infections. What does this lead back to? Supervision in the postpartum period, does it not? But a kind of supervision that takes more patience, time, and frequency of visiting than we have been willing to allow, and nurses better prepared for maternity work than we have in sufficient numbers as yet.

*Grules, C. G., Sanford, H. N., Herron, P. H. "Breast and Artificial Feeding Study Made in Chicago." *Journal of the American Medical Association*, September 8, 1934, p. 735.

Presented before the Round Table on Nursing, The American Congress of Obstetrics and Gynecology, Cleveland, Ohio, September 14, 1939.

*U. S. Children's Bureau. Proceedings of Conference on Better Care for Mothers and Babies. Publication No. 246, U. S. Children's Bureau, Washington, D.C., 1938.



A Letter from Tientsin

The district public health
nurse watches the midwife
start off to a delivery

Dear Editor:

In spite of the fact that this part of country has become "occupied territory" and in spite of the big flood of last summer in this area (some of the province is still under water), public health work has progressed. Hopei Province, in which our work is carried on, suffered from drought last summer—although it is only a few miles away from the flooded area.

In this province our organization has nursing services in six districts, each with a staff and a public health nurse supervisor. The staffs are of varying sizes. These six districts include the cities of Peking and Tientsin.

A few weeks ago I accompanied a group of visiting students from the School of Nursing of the Peiping Union Medical College* on a visit to a town in the Tientsin rural district, corresponding

to the American county seat. Because this is a rural experimental center, a nurse and midwife have been in residence at the parish church for several months. Their work includes a daily clinic, maternity service (which takes them into the country and nearby villages), school health work, classes in hygiene for women, and health clubs for children. There are enough families able and willing to pay for the services of the nurse and midwife so that the income usually covers the midwife's salary.

Trachoma is decreasing in the two town schools. It would be impossible for the nurse to bring about this gratifying result by herself. The teachers are unusually coöperative, and now carry on the eye treatments with the nurse's supervision. Simple, practical health lessons prepared by Miss Wang Hsui-ying* of the Health Center of the Peiping Union Medical College are used by the

*Although the pro-Japanese administration in Peiping announced on December 14, 1937, that it had restored the city's old name of Peking, the Peiping Union Medical College retained the name it had taken during the period the city was called Peiping.

*Miss Wang received her Master of Arts degree at Teachers College, Columbia University, New York City, in 1936 and is now carrying on an experimental health education project for primary schools.

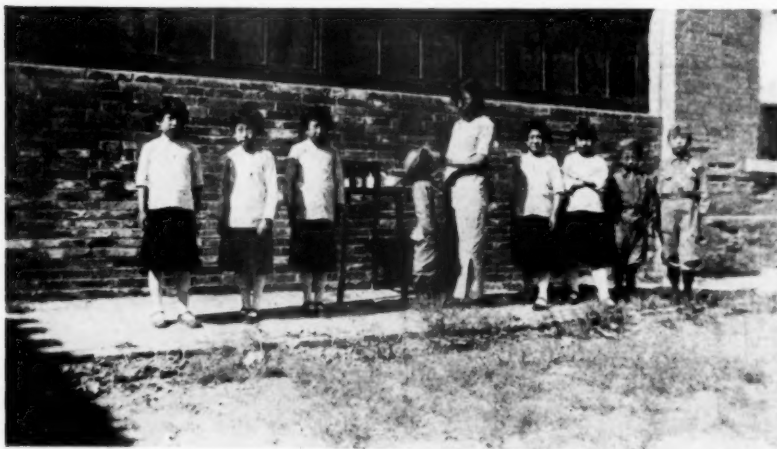


The public health nurse and the midwife are off to answer a call from a patient in the country

teachers, and more important, the lessons are carried out in actual practice. The school has made provision for the children to wash their hands. The toilets are clean and sanitary. The visiting students said that they were in better condition than the ones they had seen in Peking city schools. The nurse is invited to give immunizations. The school pays for the simple remedies needed at the school.

I was impressed by what the local

health committee has accomplished by its own efforts. The church has two clean, sanitary privies of simple, inexpensive construction. A place has been fenced off in the churchyard for the disposal of refuse, which is properly cared for. A drain has been put in the yard to carry off dirty water. The church and the pastor's house have been screened. We visited the homes of the chairman and another member of the committee and found sanitary privies installed in



The country school teacher carries on alone



Nutritious soybeans drying in a village

each one. That is most unusual. Ordinarily, if we can get a church to install two, we feel that something important has been accomplished. In each of these homes there is a screened cupboard for dishes and food as well as screened rooms. Each household has prepared extra dishes and chopsticks so that hygienic eating habits are possible. In one family, a small five-year-old daughter used them quite naturally. Each home has a first-aid box to care for small accidents and simple illnesses.

The health committee had bought health books and subscribed to a national health magazine for the church library.

While such accomplishments are exceptional in our rural churches, this group and others with smaller accomplishments make us hopeful that a healthful environment will gradually become the rule in our North China area.

Sincerely yours,

LORA I. BATTIN, R.N.

*Director of Public Health Nursing
North China Methodist Mission
Tientsin, China*



A mother and baby who received care from the maternal health service typify the new China of the future

Medical Social Needs of the Crippled

By GEORGIA BALL

All workers and agencies who participate in a program for crippled children have a part to contribute in fulfilment of the child's medical-social needs

THE CRIPPLED children's service under the Social Security Act is a medical program with a social goal. We are concerned that each child shall have adequate medical care and that the care given shall be of ultimate value to him as a person and as a potentially useful citizen of the nation. The concept of adequate medical care has broadened in the past decade. The futility of treating people as merely pathological cases has been demonstrated. Physiology and psychiatry have contributed to our knowledge of the interrelation of mind and body, of emotions and glandular reactions. Life is not divided into compartments; hence the whole child, not just his crippling condition, must be provided for if adequate medical care is to be given.

We are concerned that the disability which the child retains shall be as inconsequential as possible. By locating him in the early stages of the crippling condition, by assisting him to secure skilled surgical treatment, care in hospitals with high standards, and good public health nursing, and by providing him with medical follow-up care, we endeavor to make the physical handicap as small as possible. Yet in many instances some disfigurement or deformity will be retained throughout life. The extent to which this physical handicap is actually disabling to the person varies greatly. A limp, for example, may ruin one person's life; it may mean nothing to another. The extent of disability depends not only on the physical handicap but

also on the individual's attitude toward his handicap, the attitude of those around him, his scholastic preparation, his occupation, and the goals he has set for himself. To make disability—in the broad sense—as small as possible requires more than surgery, medical follow-up, and good physical care.

This discussion will endeavor to show that medical-social work is a broad term which is not confined to the activities of medical-social workers alone. Every sick person must be accorded consideration of the interplay of medical and social factors if the broad goals of good medical care and minimum disability are to be achieved. The crippled children's program affords good illustration of this interplay at various points in medical treatment. It also brings out the methods by which nurses, doctors, administrators, child welfare workers, and others contribute to the fulfilment of a child's medical-social needs.

THE ACCEPTANCE OF MEDICAL CARE

The first instance of this interplay may be encountered in the family's or the patient's acceptance of care. In the majority of cases, when crippled children have not had medical care it is because the parents have not had the means or the opportunity to obtain it. They usually have felt keen sorrow that the child could not play as other children do, and have realized the boundaries which the physical handicap would place on his future opportunity for self-realization. When the crippled children's services

offer treatment, their concern is to know that the child will receive good care. Their worries usually are merely about whether an operation will be needed, how long the child will be away from them, whether the surgeon is competent, and when they can visit the child. Consequently, if adequate interpretation is given and sufficient confidence in the surgeon and the agency is built up, the parents eagerly desire the proffered treatment. They have unconsciously correlated social factors with medical needs because they have already weighed values.

Not infrequently, however, parents refuse to bring children to diagnostic clinics, or refuse to allow surgery if surgery is recommended. The action which we take in such a situation depends on both the medical and the social factors involved.

Let us examine the medical factors in an imaginary case. Suppose we find that ten-year-old Dorothy had infantile paralysis 18 months ago, and that she has some shrinking and deformity of the right arm and leg. The orthopedist tells us that treatment is urgent, both because the child's deformity will increase with time if she does not have treatment, and because treatment should be started immediately so that the muscles may be protected against further damage and so their comeback powers may be aided as much as possible. Urgency, the first important medical factor, is therefore established.

The nature of the treatment is the next factor we will wish to ascertain from the surgeon. Is an operation necessary? If so, how dangerous is it? How long will Dorothy remain away from her home? Will she be obliged to return to the hospital frequently for follow-up care? Will it be necessary for her mother to supervise her exercises in the home? Most important of all, what is the expected outcome? Suppose the answers to these questions reveal that

treatment will consist of braces and exercises at present, and that an operation to transplant a tendon may be necessary later on. At the present time two or three weeks in the hospital are necessary to institute physical therapy and fit the braces. The doctor also says that a very good outcome is expected from the treatment.

"A GOOD OUTCOME IS EXPECTED"

Perhaps it is well to pause for a moment and examine what the doctor means by the term "good outcome." All of us members of the laity—and this includes the parents—are so attuned to the miracles of orthopedic surgery and so accustomed to thinking of "cure" as something which makes us completely well that we are apt to consider "good outcome" as complete restoration of function of the crippled part. The surgeon, on the other hand, uses the term from the standpoint of what is good in the light of what there was to begin with, or in the light of what he knows of the disease process. Sometimes the doctor urges treatment because of his knowledge that serious damage will occur later without such treatment. The child may return home medically cured but with as severe a deformity as when he entered the hospital. The outcome of the treatment may be excellent from the standpoint of halting the disease process, eliminating pain, and restoring the use of a limb, but the child may be left with a stiff knee or a limp due to shortening of the leg.

In the case of Dorothy, the outcome may be excellent from the standpoint of preventing further deformity, aiding certain muscle action, and providing a more normal gait. But the shrinking of her limb probably will not be appreciably lessened. Her gait may still be different from that of other children. Some muscle function probably will never return. And she may even have to wear a brace all her life.

Failure to understand the amount of restoration of function the doctors expect not infrequently causes us to build up a much too hopeful picture in the minds of parents, with consequent disillusion and disappointment to parents and child and loss of their confidence in us.

Suppose we receive from the doctor the interpretation that "good outcome" in Dorothy's case means that she will probably walk with a slight limp, that she may never be able to use all her fingers, and that her right arm and leg will always be somewhat thinner than the left. But if she is not treated—and this is another important question to ask the doctor—she may have a very noticeable and peculiar gait and an almost useless arm. So the outcome of treatment is really "good" from the standpoint of what it will mean to the child's future life.

WHAT IS THE SOCIAL SITUATION?

Now that the major medical factors have been examined, let us look at the social situation. Let us assume that Dorothy is a lively, attractive child who has never done outstanding work in school, but who has kept up in her grades. She has no behavior problems but is already sensitive about her limp. She has no exceptional talents. Her mother is a widow with two younger children. As nearly as we can predict, Dorothy will have to make her own way in the world, probably among the white-collar group, and perhaps help her younger brother and sister through high school. Medical and social factors indicate that this situation merits our giving ample thought to understanding the mother's point of view and helping her to see the value of treatment—a situation worth all our ingenuity and the use of every available resource.

The skillful public health nurse realizes that if she is to help the parent see the value of treatment it is absolutely

necessary for her to understand the parent's point of view. Pleading, arguing, and threatening are of no more value in overcoming resistance to care than in solving any other social problem. A serious error to be avoided by the nurse or social worker is that of talking too much herself, instead of giving the parent sufficient time to express his feelings about the child's condition and his views of the treatment suggested. This not only wastes effort by talking in the dark but it also builds barriers in the parent against medical treatment.

LEARN THE REASON FOR RESISTANCE

Unless the reason for resistance is known, the resistance cannot be overcome. If, for example, the parent is firmly convinced that we want to take the child into the hospital so that medical students can experiment on him, no value comes from talking about how necessary it is that a certain disease process be halted. The need for ample time so that the parent will reveal his views is stressed because frequently the parent at first gives some minor reason more plausible than the one that is really worrying him. And not until he has found his listener to be an understanding person capable of seeing all points of view does he reveal the real reason for his resistance. Haste, pressure, condescension, and impatience are barriers to achieving the end in view.

Perhaps the mother first says that she doesn't want treatment because Dorothy is improving without it and she doesn't want the child so far away from home. But soon she reveals to the sympathetic listener that Dorothy was her rather's favorite child and that since his death the mother has felt a sense of special trust for the child and closeness to her. When the epidemic included Dorothy among its victims, it seemed more than the mother could bear. She felt especially frantic because she had not had much faith in doctors since her hus-

band's death, and felt that there was no one on whom she could really rely. The doctor who had attended her husband just before he died had given her the impression that if the other doctors had given him different treatment he would have lived. In addition, the father's mother, who has always mistrusted doctors and hospitals, has been especially bitter since her son's death, and has influenced the mother against calling one.

UNDERSTAND THE MOTHER'S FEARS

The mother had decided to give Dorothy the best care she herself could give and had massaged the child's leg and arm every day with olive oil. For a time Dorothy improved and the mother was satisfied that she had done the right thing, but lately she had begun to worry because the child frequently complained of being tired and her limp had become worse. So she let the child go to the diagnostic clinic because the school nurse had urged it, and the mother had always liked the nurse. But when the doctor said Dorothy would have to go to the hospital the mother just could not face the prospect. Maybe the doctor would make a mistake and the child would lose the use of her leg entirely, and then how would she be discharging her trust to her husband? And she was sure Dorothy would cry if she were taken so far away from home. So she had decided to wait a while longer and try mixing the olive oil with a little ointment which she had heard would strengthen muscles.

The listener, a nurse or a social worker, tells the mother she can understand her reluctance to give over Dorothy's care to a strange doctor and let her go away to a hospital when she feels the way she does about her husband. The listener asks if the mother has been able to talk with the orthopedist at any length, and tells her a little about his reputation, his experience, and his interest in children. She asks if the mother knows that an

operation may not be necessary and that exercises and possibly braces may be all that is necessary at this time. The mother had thought an operation would be performed right away and had not realized that she would still retain the major responsibility for Dorothy's treatment by giving her directed exercises at home. She seems interested and agrees that she would like to get better acquainted with the doctor and learn more from him. An appointment is made for her to talk with him. No decision is pressed at this time.

The school nurse is asked to drop in to talk with the mother after she has seen the doctor. The next time the nurse or social worker calls, the mother agrees to allow Dorothy to go to the hospital but she seems very much worried about not being able to go with her. Out of respect for the mother's feeling of special trust for Dorothy, arrangements are made to leave the other children with the grandmother so that the mother can stay in the medical center during Dorothy's hospitalization.

Someone might raise the question as to whether any action is taken to help the mother overcome her obvious feelings of overprotection for the child, foreseeing the difficulty which this child may have in establishing independence later. We hope that there is a medical-social worker at the hospital who can be told of the circumstances previously described, and who will talk over these things with the mother while she is in the medical center, or that the public health nurse who knows Dorothy at school and the child welfare worker will take up the situation after the child and her mother return home.

The reader may feel that this is a simple situation, but the majority of the problems we encounter are simple if we take time to understand the other person's point of view and to give as much weight to what is important to him as to what seems important to us.

DEFORMITY NOT ALWAYS A HANDICAP

Another case may be described briefly for comparison with the one just examined in detail. John, a twelve-year-old boy, has an old fracture which has resulted in a crooked elbow. The orthopedic surgeon reports after the examination that he believes he can give the boy good use of his arm, although an operation in three stages will be necessary and will involve a period of six months, two of which probably will be spent in the hospital and the remainder at home with the arm in a cast. No urgency exists because the boy's deformity will grow neither better nor worse with time. Social examination reveals a dull farm boy, large for his age, who has failed in two grades in school. He likes cattle and horses, and he prefers plowing to books. His handicap does not interfere greatly with farm work; in fact, he is exceptionally skilled in handling a team already. He is in no way sensitive about his crooked elbow. An estimation of the future is that this boy will be a farmer and that his deformity will not be a serious handicap to him. Our conclusion is that if he and his parents desire treatment it should be made available to them, but that treatment should not be urged.

Another point where the weighing of medical and social factors is necessary is in the establishment of financial eligibility. A child's financial eligibility is based not alone on his family's income and ordinary expenditures, but also on the estimated cost of the largest item in the budget, that of treatment for his crippling condition. Costs other than those of hospitalization, surgeon's fees, x-rays, and so forth, are included. The probable cost of extra food and other essentials during the child's convalescence and the probable extra costs for special education or transportation must also be computed. The child's eventual ability to support himself is another important factor. The medical care of

a crippled child may cost from \$1 for a lift on a heel to \$1000 for hospitalization, surgery, physical therapy, and appliances. To determine a child's financial eligibility we must keep in mind all these factors. This estimate can be obtained only from the child's physician and the administrator of the crippled children's program.

The health needs of other children in the family likewise enter in. In our emphasis upon one member of the family we may deprive others of the necessities of life. This is especially true where the crippling condition indicates lack of nourishment or poor food habits and living conditions in the family as predisposing causes. Hence it is obviously not possible to determine financial eligibility until after the diagnosis has been established and the necessary data obtained from the administrator of the program.

SELECTING PATIENTS FOR CARE

The selection of patients for treatment when there are long waiting lists requires most careful judgment of important medical and social factors. Children needing emergency medical or surgical treatment are given first consideration, and children with urgent medical and social needs are selected next in order. Should a 13-year-old girl with hareip and cleft palate be selected before a young baby with club feet? Not ordinarily. A patient in whom further deformity can be prevented, but who if not treated now will require larger expenditures for treatment in later years usually requires prior selection on the basis of the medical need and the probable outcome. But it is only by comparing the total values to the children involved that a decision can be made. If there are times when the community becomes impatient over the delay in the treatment of a particular child it should be remembered that there may be many other children medically or psychologically in more urgent need of treatment.

Determination even of the type of treatment to be given a child may not infrequently rest on the surgeon's consideration not only of the medical needs but also of the social factors that have been reported to him. Whether care can be given in the home instead of the hospital, how much should be risked when the surgery is extremely dangerous, whether it is wise to stabilize a foot by surgery or to rely on long-time correction by braces and exercise—such decisions as these frequently depend on the intelligence of the parents, the living conditions, the attitude of the child toward the crippling condition, and his probable future occupation. The length of hospitalization and the consequent cost to the agency obviously depend on how soon a child can be discharged safely to his home, or to a substitute home if there are facilities for convalescent care.

SOCIAL FACTORS OF AFTER CARE

At the time a child is to be discharged from the hospital or convalescent home the arrangements made for his aftercare so commonly demand the weighing of medical and social factors that medical-social workers are possibly prone to give more attention to this phase of care than any other. During this period, it is possible for all the benefits of surgery to be lost if the family is unable or unwilling to carry out the recommendations made.

The simplest of recommendations, that of returning the child to the clinic for supervision at the end of three months, may not be carried out if the family has not had adequate interpretation of the necessity for this supervision or if no transportation facilities are available. The apparently simple order, "a well-balanced diet," is frequently the most difficult one to carry out and requires special provisions in many instances. The wearing of a brace may be of vital importance to the child's future, yet the mother may be too exhausted to keep

after a mischievous child who takes it off as soon as she puts it on. The feasibility of another frequent recommendation, that of keeping the child in bed or at least off his feet for all or part of the day, may depend on the disciplinary habits of the family and on the mother's time, energy, ingenuity, and freedom from worry.

It is ironical but true that a hundred dollars spent for hospitalization may be lost for lack of ten minutes of interpretation, for lack of ten dollars worth of transportation or food, or because of a mother's fatigue. Since this is true, the conditions that are important medically and the factors that exist socially must be weighed and then plans made accordingly.

PLANNING FOR THE CHILD'S FUTURE

Let us turn from the necessity of medical-social planning for the sake of adequate medical treatment to its desirability in relation to the future of the child. The stories of two children will illustrate some of the many points which might be brought out. Because of a curious coincidence they may easily be compared. They lived not more than 50 miles from each other, each in his respective county almshouse, and they suffered from an almost identical disability.

Tommy had been brought to the almshouse while an infant and placed in the care of a senile old woman. The keeper of the almshouse had not seemed interested in doing anything more than carrying out his obligation to shelter the child and supply him with food. Old Hattie kept the child, who was thought to be an idiot, on a pile of sacks by her bed at night and pushed him around in a washtub by day. Tommy could feed himself and could talk by the time he was discovered at the age of seven but he could not walk or care for himself and he had the mannerisms of an idiot. Nevertheless, he was taken to a hospital where over a thousand dollars was spent for surgery and physical therapy. Surprisingly enough, Tommy learned to walk and to care for his own needs, and his speech improved. Obviously, this boy had a fair degree of mentality

or he could not have coöperated in treatment to this marked extent.

At the end of the hospitalization period he went back to the almshouse. An effort was made to remove him to a better environment. But because he had had no one to imitate but a demented creature, and because he had been completely deprived of the training on which mental testing is based, sufficient proof of normal mentality could not be obtained to enlist the county judge's interest in paying for boarding-home care while investigation was made about the child's own relatives. Tommy's problem was so difficult and his outlook so uncertain that the limited child welfare services available could not be used for him. So he is in the almshouse to this day, so far as I know, learning life from old Hattie. He will be a charge on the county as long as he lives. The money expended for hospitalization has been wasted and the goal of useful citizenship lost for lack of social services.

Sally's story, happily, has a different ending.

Sally was discovered hopping like a frog about the skirts of her feeble-minded, unmarried mother in another almshouse. She seemed more animal than human. The change in her appearance was so marked after the beginning stages of treatment, and her comprehension so obvious, that a child welfare worker undertook the long, difficult process of transforming the child's opportunities just as the surgeon and physical therapist had transformed her body. The worker succeeded in obtaining a boarding home for Sally so that she could enter school and begin to learn something of normal living in the interim between periods of hospitalization. Finally other relatives were traced and eventually Sally was placed in the home of a cousin.

Several years have elapsed and the child welfare workers still call on Sally and her cousin's family occasionally to help with problems that arise. The author happened to see Sally the last time she was in the hospital and found it hard to believe that the alert, attractive child who walked with steadiness, talked intelligently, and shared the interests of the other children was the girl who had been found hopping about in the almshouse.

These are stories of extremes, but the principles involved are those encountered in work with any crippled child who needs assistance in bridging the gap between medical care and normal living. We do not have statistics that show how

many crippled children need help during the transition process; but experience indicates that during this process observation is justified for any child who retains noticeable deformity or who has been considerably deformed over a period of time, and that he should be given such help as he may need. It is just as desirable to consider medical factors when making plans for social treatment as it is to consider social factors when making plans for medical treatment. Though the social agency's point of view in approaching the problem may be different from that of the medical institution, the problem remains the same because all factors in the life of the sick individual must be treated as parts of a whole.

CONSIDER THE WHOLE FAMILY

Every phase of family and personal life may be affected by the illness or crippling of one member of the family. Anything that serves to pivot attention, funds, or energy on one member to the exclusion of the others will result in unbalance. Grace Gertrude Hoopes' book, *Out of the Running*,* the autobiography of a spastic, makes one wonder how different her sister Ella's life might have been had it not been spent in waiting on her little invalid sister. The income of this family must have been severely strained in their exhaustive efforts to obtain medical care for the invalid and to provide her with pets, special chairs, and a comfortable existence. How many family quarrels revolved around the constantly recurring problem of who would stay at home with her? How much shyness may have developed in the other children from being seen on the streets with their queer-looking sister?

This family was financially self-sufficient and able to offer protection and comfort to their crippled daughter. But

*C. C. Thomas Publishing Co., Springfield, Ill., 1938.

what about marginal families and those on relief? We know of the bitterness of some parents because they cannot provide the comforts so obviously needed, and of the attitudes and situations that grow up in crowded homes where malnutrition, overwork, and often ignorance may make mental and physical health impossible. Family budgeting, employment, child guidance, vocational training, domestic relations, school plans, recreation, plans involving the use of relatives—any one or all of these may be affected by the illness of a member of the family.

The social worker who encourages a child with muscular dystrophy to plan on the time when he will be well, not having learned that his visits to the doctor are for observation, not for care, and that he will never be well; the worker who helplessly watches the breaking up of a home because of the mother's irritability, not learning that she has an abnormal thyroid condition and that her frayed nerves could be helped by medical treatment; the worker who sees the disorder in a home without learning that the mother's fatigue and backache could be overcome by medical treatment for a gynecological condition; or the worker who budgets for a year on the basis of a special diet for an individual who will not need the diet at the end of three months—these are workers who have not yet learned the necessity of considering medical needs and probabilities when making plans for social treatment.

ALL AGENCIES PARTICIPATE

The medical-social needs of the crippled child are not limited to those which can be met by medical social workers alone. The burden rests equally on every individual and agency that works with a crippled child to consider both his medical and social problems and to act according to the best plan that comes from this integration. Consistent pooling of information, joint

planning, and coordination of activity on the part of health and welfare agencies are required if coordination of medical and social factors is to be achieved. Also required are adequate time, flexibility in relationships, and effective interreporting procedures. The desire for coordination is widespread, but translation of the spirit into effective working relationships requires much greater effort than we yet have put forth.

THE MEDICAL SOCIAL WORKER

In considering the contribution of the medical social worker to the program, it should be borne in mind that she is first of all a social worker. This means that she will focus her efforts on achieving the ultimate well being of the individual and not on achieving health as an end in itself. Her special skill is that of understanding the problems of sick persons and of helping them to achieve the best adjustment of which they are capable. Hers will not be the educational approach, but the case-work approach.

The difference between her contribution and that of the family worker, the children's worker, or the psychiatric social worker is in the adaptation by the medical-social worker of the knowledge and technique of social work to a medical goal. She confines her activities to problems that affect medical care and the adjustment of the sick person to his medical problem. The most important special knowledge that she brings is that of how to correlate the implications of a person's illness with his personal and environmental problems.

Medical-social workers in a crippled children's agency serve in a variety of ways depending on the needs and organization of the agency. At present, the majority of these workers spend the greater part of their time in coordination of health and welfare resources for individual patients. This is accomplished by giving consultation services to nurses and to welfare workers; by accepting responsibility for certain phases of the

program that have a large social element, such as making plans for the discharge of patients from hospitals or convalescent homes; by participating in the educational plans of health and social agencies; and by holding local conferences and demonstrating service—all

that promotes wider understanding of the significance of crippling and mutual effort in behalf of the child's care and adjustment.

Presented at the Kentucky Conference for Social Workers, Louisville, Kentucky, October 12, 1939, by Edith M. Baker.

News from the S.O.P.H.N.'s

THE IMPORTANCE of developing industrial committees or sections in state organizations for public health nursing was unanimously agreed upon by the members of the Council of Branches during its annual meeting in New York City in January 1940. Such sections or committees bring industrial nurses from all parts of the state together for discussion of their common problems, and they also bring industrial nurses in contact with other public health nurses, to their mutual advantage. In addition, lay members of state branches have opportunities to learn at first hand about industrial nursing and as a result they can often find ways to promote this important nursing service.

In 1939, seven state organizations reported that industrial nursing sections had already been formed, and during 1940 most of the rest have organized such groups. This development is especially timely since activities in connection with national defense are now causing increased concern for the health of the worker throughout the country. As a result there will doubtless be more opportunities than ever before for S.O.P.H.N.'s to participate with other state groups in plans for meeting the health needs of industry.

Several state organizations have recently sent reports of their activities in relation to industrial nursing and these

are probably typical of similar undertakings in all states. Doubtless most state branches included industrial nursing topics in the programs of their state meetings during the fall. Georgia planned a symposium on industrial nursing. The Industrial Nursing Section in Minnesota held a dinner meeting at its convention to stimulate interest in industrial health among all nurses. Pennsylvania was able to secure Joanna Johnson, chairman of the Industrial Nursing Section of the N.O.P.H.N., as a convention speaker.

Nurses are also taking part in more general meetings on this subject. In Saginaw, Michigan, according to a report from the president of the Michigan state branch, the industrial committee of the Saginaw Medical Society held an institute on industrial health and safety during November to which all industrial nurses were invited.

The Industrial Nursing Section of the Massachusetts Organization for Public Health Nursing held a meeting in November with industrial physicians, executives in industry, personnel men, and safety engineers in order to plan a winter program along lines suggested by this representative group. This section also reports having received letters from Dr. Thomas Parran, surgeon general of the U. S. Public Health Service, and from Dr. Donald M. Shafer of the Committee on Healthful Working Conditions of the

National Association of Manufacturers, stressing the need for preparing more industrial nurses in order to meet the additional demands created by the National Defense Program.

These are examples of worth-while projects concerned with industrial nurs-

ing as reported by a few state branches. This column would welcome more industrial nursing news from S.O.P.H.N.'s.

RUTH HOULTON

Secretary, Council of Branches, National Organization for Public Health Nursing

Christmas is for Children

These suggestions for meeting problems of the Christmas season are taken from *Parents' Magazine* for December 1939

GRANDMA has an excellent idea for keeping the three-year-old busy and happy:

"Christmas before last I watched my daughter-in-law trim the tree. Tim, Junior, was spanked no less than seven times for wanting to 'help.' He was called 'bad boy.' Of course he almost knocked the tree down. Of course he broke some ornaments. Of course he got in his mother's way. But what could you expect of a three-year-old healthy boy? I made up my mind it must never happen again. It hasn't. Last Christmas I gave him a small tree of his own with plenty of ornaments so that if he broke a few he would still have enough left to trim his tree. You'd be surprised at the taste he displayed and the interest he took in it. All through the holidays he trimmed and retrimmed that tree and each time he showed more originality. He showed it with great pride to visitors.

He played Santa for his six-months-old brother, too, and every time the baby let out a sound of appreciation Tim, Junior, would say, 'See! He likes the way I trim it!'"

A MOTHER who *doesn't* tell her little girl that there is a real Santa Claus writes:

"She gets just as much thrill out of Santa Claus as I ever did. Yet she knows him as a pretend person, like Jack Frost, the Fairy Godmother, or the Wizard of Oz. We visit the stores before Christmas and she gets in line to talk to Santa Claus. She seems to enjoy it all the more because it's so much fun to pretend. She understands that many children do not know about the real Christmas yet and that she mustn't tell them. She knows from whom she receives her Christmas gifts and thanks the giver as a matter of course. She knows that the reason she didn't get that big bicycle is that her father couldn't afford it, not that she hadn't been good enough."



The School Child's Teeth

By F. C. CADY, D.D.S., AND W. J. PELTON, D.D.S.*

Problems that arise in planning dental programs for school children and suggestions for a sound program are discussed in the fourth article of this series

DENTAL surveys of school children indicate that a vast number of children do not receive adequate dental care, in spite of the increasing emphasis on health education. Except for isolated examples, dental programs for school children are for the most part lamentably inadequate.

In the simplest terms, the problem confronting us is mainly one of preventing the loss of teeth. In the light of our present knowledge concerning dental caries, the only efficient and reliable way of preventing the loss of teeth is to have cavities filled before caries extends to the pulp of the tooth. The earlier the cavities are discovered and filled, the cheaper the treatment becomes. Expensive and involved remedial tasks are thereby eliminated. At the same time, early and periodic care of the teeth is less painful to the patient. Briefly, then, an adequate dental program for school children consists of early and periodic care of every child's teeth by a dentist.

FROM BIRTH TO EIGHT YEARS

Since no significant calcification of the permanent dentition takes place *in utero* and since all the permanent teeth are calcified after birth it becomes evident that the child's nutrition and well being have an effect on the permanent teeth (except the third molars) from birth until about eight years of age, at which time the crowns are completely calcified. There is almost complete agreement in dental research circles that fully formed enamel is not a "vital" tissue.

This means that the food a child eats up to eight years of age is important in forming normal teeth but after that period the metabolic processes occurring in the enamel are insignificant.¹ Proper diet is important at all ages, but as far as tooth substance is concerned, food after eight years of age affects only the oral environment of the tooth. However, the health of the soft tissues of the mouth is affected throughout life by the individual's nutrition.

The difference between children, in the time of shedding deciduous teeth, causes a great deal of confusion.² There is a reluctance on the part of the dentist to fill deciduous teeth which may be lost in a few months. Likewise parents hesitate to pay for dental work that will not be in the child's mouth very long. Since the physiological age of the tooth is not identical with the chronological age of the child it becomes necessary to verify the exfoliation process by means of x-rays.

POLICY REGARDING BABY TEETH

In well regulated dental practices and programs, a definite policy is adopted concerning the filling of deciduous teeth. In general it seems best to agree that deciduous teeth which are to be in the mouth three months or longer should be treated. Deciduous teeth that are carious and will not be exfoliated within six months should be filled with a per-

*Domestic Quarantine Division (State Relations), U.S. Public Health Service, Washington, D. C.

manent filling material. In any event if a deciduous tooth cannot be successfully treated it should be extracted. "Temporary fillings for temporary teeth" are now being abandoned by the leading practitioners and teachers. Likewise, nonvital diseased teeth or those deciduous teeth responsible for fistulas and abscesses are to be removed if they cannot be successfully treated, so that the foci do not remain. One cannot find in the dental literature any authority who advocates the retention of such teeth for "space maintainers."

The best "space maintainers" are normal, healthy deciduous teeth. If one had to choose between possible ill health and crooked teeth the choice should be crooked teeth. In any event the dental care that a child receives is only a part of the whole health program for that child. No reliable statistics are available to indicate the probable number of cases of malocclusion resulting from the early loss of deciduous teeth. Clinical experience reveals that the premature loss of the foundation molars may result in a drifting of the first permanent molars. Consequently, the best advice to those concerned is to place the child in a dentist's care so that he may judge whether a retaining device is necessary.

The premature loss of deciduous incisors does not present the same difficulties as the premature loss of posterior teeth. Usually there is a lateral growth that takes place between the cuspid teeth which allows the small deciduous incisors to be replaced by larger permanent incisors. Except for the cosmetic or aesthetic feature of such a loss, the spaces seldom create a problem in the average child.

On the other hand, if for some reason a deciduous tooth or a fragment of a broken-down deciduous tooth is retained too long, the erupting permanent tooth may be forced into an abnormal position by the growth processes. This, of course, is a condition that can be prevented by

extracting the offending deciduous tooth or fragment at the proper time, as determined by an x-ray.

In judging the time of eruption of permanent teeth as well as discerning the relation of the permanent teeth to the too-long retained deciduous teeth, an x-ray is most important. Parents should be urged to seek this service for their child. An x-ray not only is an aid to the dentist in discovering caries early but it may also be of value in preventing the extraction of healthy deciduous teeth which have no permanent successors.

SCHOOL DENTAL HEALTH PROGRAM

Since the real aim of a dental program is the prevention of the early loss of teeth—deciduous and permanent—an effective preventive program in dentistry implies that remedial care is being undertaken along with a suitable educational program.

The effectiveness of any dental program can be measured from year to year by computing the reduction in the number of lost permanent teeth per 100 children. Reports on the number of fillings or the number of prophylactic treatments given mean very little. Such reports give no indication of the number of children who have received complete care and whose mouths are free from caries, broken down teeth, and other pathogenic conditions.

Two general kinds of remedial dental programs are being sponsored in the United States: the clinic type and the nonclinic type.

In the clinic type of program some agency—such as a school, a foundation, or a group of dentists who voluntarily give their time—attempts to render service to all or part of a school population. It is interesting to note that the Educational Policies Commission of the National Education Association has recommended "That medical diagnosis and treatment for school children, with certain emergency exceptions, be pro-

vided by agencies other than the public schools." However, the policy of the same organization is "that the schools assume full responsibility for health instruction and health inventories of pupils."³

Too frequently the clinic type of program is overtaxed by the number of children applying for treatment. When this occurs, the policy becomes, "do a little for each child," or "do emergency work only." In this case, the dental program degenerates into a relief measure that accomplishes nothing in the way of preventing the loss of teeth. In some clinic programs the number of children is so great and the funds are so meager that only permanent teeth are treated. The adoption of this policy is unfortunate. It is important that the deciduous teeth be filled in six-, seven-, eight-, nine-, and sometimes ten- and eleven-year-old children to prevent their loss and the possible resulting malocclusion. It is also extremely important that deciduous teeth do not become a source or a foci of infection.

WHAT IS BEST KIND OF PROGRAM?

What then should be the policy of a dental program? The studies made in

Hagerstown, Maryland, have shown that the problem of children's teeth becomes one of preventing the accumulation of dental defects.⁴ In these studies⁵ it was shown that the rendering of complete service in the form of fillings for permanent teeth of the children in that community would take 30 percent of the available dentists' time. To keep up with the yearly amount of caries would require 10 percent of their time. But actually the dentists were spending only 2 percent of their time on children.

The following program is suggested for a dental clinic. If a well regulated clinic were to limit its patients for the first year to only a small age span—the first to fourth grades, for instance—and give complete treatment to those children and emergency treatment to the older groups, its program would become more effective during the following years. In the second year of the program, children one year older could be included, together with the new first-grade children. In four years, the children from the first to the seventh grades would receive complete care for about the same expenditure of time as it took to treat the original four grades. In the meantime the emergency extractions would be

CALCULATION OF YEARLY INCREMENTS OF NEW, DECAYED, MISSING, AND FILLED PERMANENT TOOTH SURFACES, BY SPECIFIED AGES (HAGERSTOWN, MARYLAND)⁴

By age of school child	Number of DMF* permanent tooth surfaces observed per 1000 children	Expected number of new DMF* surfaces between age specified and previous age per 1000 children
6 years	382.3	382.3
7 years	1,007.4	625.1
8 years	1,714.6	707.2
9 years	3,789.9	2,006.3
10 years	4,867.7	1,086.8
11 years	5,194.0	326.3
12 years	7,139.3	1,945.3
13 years	9,299.1	2,159.8
14 years	10,537.9	1,288.8
15 years	14,276.6	3,688.7
All ages		1,427.7**

*Decayed, missing (extracted) because of caries, and filled. This represents past and present caries and expresses the complete caries experience.

**Average weighted for observed numbers of children in separate age groups.

NOTE: A crown of a tooth has five surfaces.

reduced and the number of lost permanent teeth would approach zero.

A nonclinic type of program is one in which remedial care is emphasized but in which only private dentists render the treatment. Frequently, these programs meet with failure because individual dentists are not equipped nor disposed to treat children. The geographic distribution of dentists often makes for unsatisfactory results also. However, with the increased emphasis on children's dentistry, and the increased interest in post-graduate work and refresher courses, the dental profession is gradually becoming aware of the importance of working in closer cooperation with the other professions which are promoting the welfare of children.

MASS EXAMINATIONS FUTILE

Many school dental health programs place major emphasis on mass dental examinations. However, since dental caries is almost universal (the Hagerstown studies show that 98 percent of the fifteen-year-old boys have one or more decayed, missing, or filled permanent teeth⁵), it seems foolish for an agency or school to spend money for dental examinations of school children in an attempt to find the few who do not need dental attention. A dental examination is a painstaking procedure and means very little unless made by a dentist under the best of conditions and with the best instruments including x-ray.

In dental circles the practice of filling pits and fissures before they decay is becoming widespread. It has been estimated that the chances are 2000 to 1 that a given fissure will decay. In other words, a good dental program will have all children go to the dentist regardless of the obvious signs of caries or the lack of them.

SUMMARY

An effective dental program for the school child is one which embodies the following points:

1. A remedial program which prevents the accumulation of untreated defects.
2. A tax-paid treatment program administered by the health department for the school population who are not able to provide dental care for themselves.
3. A continuous health education program conducted by the classroom teacher and with interesting and sound teaching units in which the pupils participate. The specific objective is to motivate the entire school population to seek dental treatment.
4. Active participation in the dental program by community groups, including health departments, nurses, dentists, parent-teacher associations, and service clubs.

EDITOR'S NOTE: This is the fourth in a series of articles contributed by the Dental Health Education Committee of the American Dental Association.

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⁴ Klein, Henry, and Palmer, Carroll E. "The Dental Problem of Elementary School Children." *The Milbank Memorial Fund Quarterly*, July 1938, p. 267.

⁵ Klein, Henry, Palmer, Carroll E., and Knutson, John W. "Studies on Dental Caries. I. Dental Status and Dental Needs of Elementary School Children." *Public Health Reports*, May 13, 1938, p. 751.

National Nursing Inventory

ON NOVEMBER 1, 1940, the National Survey of Registered Nurses was launched in the District of Columbia. As soon as sufficient returns indicate whether the questionnaire is easily interpreted by the majority of the nurses, 500,000 copies will be printed and the survey will be launched simultaneously in the 48 states and the territories of Hawaii and Alaska. It is hoped that by January 1, 1941, the survey will be under way in all of the states and territories.

The survey is sponsored jointly by the Nursing Council on National Defense and the U. S. Public Health Service. The Public Health Service is furnishing the forms or questionnaires, the franked envelopes for mailing the forms to the individual nurses, and the letterheads upon which the covering letter may be written.

The Nursing Council on National Defense (through the American Nurses' Association) has asked each state nurses' association to designate some nurse within the state who will assume the major responsibility for the survey in that state. Just as soon as the state associations send the names of their representatives to national headquarters, the Public Health Service will request the Federal Civil Service Commission to give these nurses appointments as Special Agents of the Public Health Service for a period of one year. Such an appointment enables the state representative to sign the letters pertaining to the survey and to mail those letters in franked envelopes. It is essential that your association designate a representative *at once*, if it has not already done so, so that the appointment of the Special Agents of the Public Health Service may be made before January 1.

The Public Health Service would like to have an estimate of the probable

number of registered nurses in each state. It would be helpful if this estimate were sent to the American Nurses Association headquarters by each state as soon as possible. Remember, this is a survey of *all registered nurses* in the entire nation. It is not enough to obtain a roster of the registered nurses who are actively engaged in nursing work. A questionnaire should be filled out by *every nurse who is registered in any state*, even though she may not be actively engaged in nursing work in the state where she now resides or a member of any professional nursing organization.

The National League of Nursing Education reports that almost 20,000 young women have been graduated from accredited schools of nursing each year for the past ten years. Many of these young women have married, and therefore are not eligible for military service, but in the event of a national emergency they would be more than willing to do their share by replacing in the hospitals or elsewhere those nurses who are called for duty by the Army or Navy.

The District of Columbia has been greatly aided in locating the married nurses by volunteer nurses from among that group. Special announcements made by these volunteers at meetings of women's clubs, women's auxiliaries of the medical society, the American Legion, parent-teacher association, et cetera, are bringing excellent results and it is evident that America has an impressive reserve of registered nurse power.

The questionnaires will be distributed and collected by the several state nurses' associations through their representatives who will be designated "Special Agents of the Public Health Service." When the questionnaires

have been checked or edited by the state association, they will be returned to the Public Health Service in Washington. The Public Health Service will place all the information on punch cards and will tabulate the results. For the first time in history, a complete roster of the registered nurses in America will be available. If a national emergency arises, it will be possible to know on short notice where the reserve nurses are, which ones are available for full-time or part-time duty at home or elsewhere and which ones are qualified in the special fields of nursing.

The Public Health Service suggests that each state nurses' association send its representative to Washington for a one- or two-day conference sometime

during the month of December at a date to be set. At such a conference details of the plans for the survey could be explained more fully; each state would benefit from the first-hand knowledge of the successes and failures of the techniques employed in the District of Columbia; and plans for the use of the data could be discussed.

America needs nurses to help meet the present emergency and to be prepared for any future emergency. One of the first steps in preparedness is to have a complete inventory of our resources. The National Survey of Registered Nurses is the first step in nursing preparedness.

Published in *The American Journal of Nursing*, December 1940.

Nurses Are Asking These Questions

NURSES ENROLLED in the First Reserve of the American Red Cross are now being called for service in the United States Army to meet the need for increased nursing personnel occasioned by the training of enlisted and drafted men. Some of the questions asked by public health nurses about the call of reserve nurses are answered here. Further information can be obtained from Red Cross local nursing committees or from the Director of Nursing Service, American Red Cross, National Headquarters, Washington, D. C.

Who calls the nurses enrolled in the American Red Cross First Reserve?

Nurses are called by the Corps Area Commanders of each of the nine corps areas (into which, for military administrative purposes, the United States is divided), from the reserve lists supplied by the American Red Cross.

Why are enrolled nurses called by the army instead of by the Red Cross?

In conformity with army mobilization plans and army regulations, nurses are called directly by the army as are reserve of other staff corps and arms of the service, rather than by the Red Cross as was formerly the procedure.

From which army headquarters will a nurse receive her call?

A list of Corps Area Commanders and a map showing the areas are published on page 739.

Is the call to service obligatory?

No. "No nurse will be assigned to active duty except on a volunteer [voluntary] basis with her written consent for a minimum period of one year which, under suitable arrangements, may be extended for a longer period," according to instructions issued to Corps

Area Commanders by the War Department, September 24, 1940.

What age group is being called?

Only nurses under 35 years of age are accepted at the present time.

Are public health nurses to be called?

Public health nurses will receive letters from the Corps Area Commanders, but the War Department instructions to Commanders say that "Nurses who are engaged in essential public health activities, in teaching, and in administrative positions, should not be encouraged to volunteer."

Can a First Reserve nurse who has not been called, volunteer for army service?

Yes, provided she is in the age group to be called.

Should public health nurses respond to the call upon the First Reserve at this time?

This is a matter for the individual nurse to decide, but public health leaders hope that public health nurses will remain in their jobs at present because of the need to protect the health of our communities and the shortage of qualified nurses in the public health field. If a nurse wishes to volunteer, however, she is urged to make sure that she can be replaced, before responding to the call.

What should be the response to the First Reserve call of a nurse who is a conscientious objector to war and conscription and who does not feel that the present situation justifies the calling of the reserve?

In a democracy every nurse has a right to her own belief on questions of national policy. But whatever her feelings about war and conscription, there is an existing health emergency at the

present time in connection with the mobilization of men for military training.

If a nurse has signed up for service in a base hospital unit, should she respond to the call of the Corps Area Commander?

Yes. If the need for the base hospital unit should arise, which is not likely at present, nurses serving as reserve nurses in the Army or Navy Nurse Corps may request transfer to their unit.

If a nurse is unable to respond to the call from the Corps Area Commander what should she do?

She should answer his letter at once giving all the information he requests. This is *very important*.

Are nurses being sent overseas for military duty at the present time?

No.

Are nurses being sent abroad for rehabilitation work at present?

Only one small unit is being sent abroad by the Red Cross—The American Red Cross-Harvard Hospital Unit, which is going to England for the care and study of communicable diseases under wartime conditions. See November issue, page 707.

Are more nurses needed in the Red Cross First Reserve?

Yes, nurses from 21 to 40 years of age meeting Red Cross requirements are urged to enroll so that a full list of qualified nurses may be available for any possible need, such as epidemic, disaster, or other emergencies. Nurses in the First Reserve who marry or reach the age of 40 are automatically transferred to the Second Reserve.

For additional information, see two articles in *The American Journal of Nursing*: "Red Cross Nursing and the Army," July 1940, p. 791, and "Opportunity in the A.N.C.," December 1940, p. 1366.

AREAS AND HEADQUARTERS OF CORPS AREA COMMANDERS, U. S. ARMY

First Corps Area—Army Base, Boston 9, Mass. Surgeon—Col. John V. Reddy, M.C.
Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont.

Second Corps Area—Governors Island, N. Y. Surgeon—Col. Frank W. Weed, M.C.
Delaware, New Jersey, New York.

Third Corps Area—U. S. Post Office and Court House, Baltimore, Md. Surgeon—Col. H. C.
Pillsbury, M.C.
District of Columbia, Maryland, Pennsylvania, Virginia.

Fourth Corps Area—Post Office Building, Atlanta, Ga. Surgeon—Col. J. E. Baylis, M.C.
Alabama, Florida, Georgia, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee.

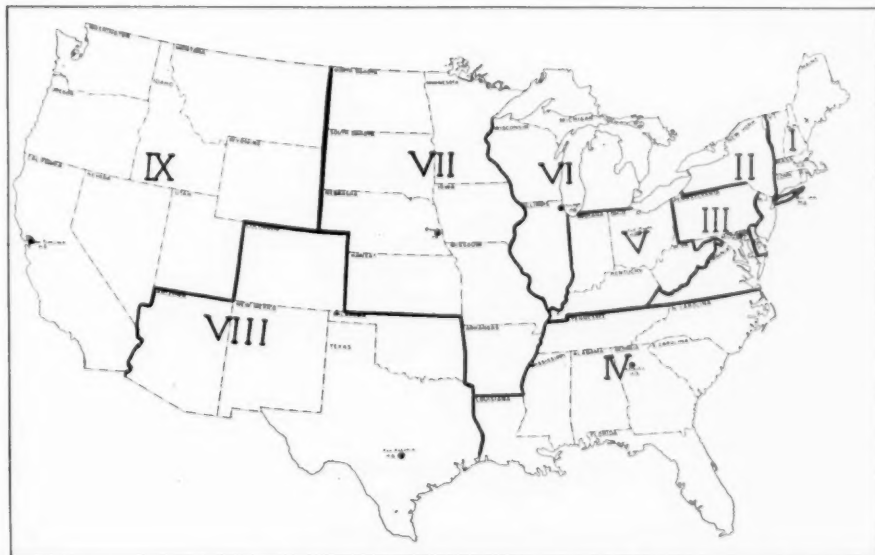
Fifth Corps Area—Fort Hayes, Columbus, Ohio. Surgeon—Col. W. L. Pyles, M.C.
Indiana, Kentucky, Ohio, West Virginia.

Sixth Corps Area—Post Office Building, Chicago, Ill. Surgeon—Col. P. W. Gibson, M.C.
Illinois, Michigan, Wisconsin.

Seventh Corps Area—New Federal Building, 15 and Dodge Streets, Omaha, Neb. Surgeon—
Col. H. C. Gibner, M.C.
Arkansas, Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, South Dakota.

Eighth Corps Area—Fort Sam Houston, San Antonio, Tex. Surgeon—Col. W. L. Hart, M.C.
Arizona, Colorado, New Mexico, Oklahoma, Texas.

Ninth Corps Area—Presidio of San Francisco, San Francisco, Calif. Surgeon—Col. C. C.
McCormack, M.C.
California, Idaho, Montana, Nevada, Oregon, Utah, Washington, Wyoming.



Visiting Nurse Contracts with Industry

By RUTH HOULTON, R.N.

How can a visiting nurse association provide industrial nursing service to small industries in the community?

TWO THIRDS of the workers in the industrial establishments of this country have no industrial nursing service, according to estimates of industrial health authorities. They usually are employed in concerns using 500 or fewer people, a large proportion of which are so small that they cannot afford—and indeed do not need—the services of a full-time nurse. Eighty percent of all factory workers in the United States are in plants of less than 100 wage earners, and ninety-seven percent are in concerns having less than 250 employees.*

Many of these industrial establishments are located in communities where there are visiting nurse associations formed for the express purpose of giving part-time nursing service and it seems strange that in only a few instances have agreements for supplying nursing service been worked out between small industries and these public health nursing agencies. Where arrangements of this kind have been tried** the results have been so satisfactory that more extensive use by industry of part-time nursing service already available in the community seems clearly justified.

Promotion of such plans is particu-

larly timely now in view of the present expansion of defense industries which are bringing increased health hazards and also increased public appreciation of the importance of the health of the worker. In the words of the surgeon general of the United States Public Health Service:

Industrial mobilization and expansion coincide with military mobilization and expansion. Although we have made progress, we still are far from solving all the long-time problems associated with occupational accidents, disease, and physical impairment among workers in ordinary times. Defense preparations have greatly augmented these problems, and created acute new ones.***

Procedure in making plans to provide industrial nursing to small industries will vary with the community and its awareness of the problem. In one northwestern city the industrial committee of the county medical society, the visiting nurse association, and the local chamber of commerce of the community are working together to develop a plan whereby every small industry in the area will have industrial nursing service supervised by the local visiting nurse association.

SURVEY OF LOCAL INDUSTRIES

In many communities, however, initiative in making contacts with industry must be assumed by the nursing agency itself, and a survey of local industries to determine which ones do not have nurses and which of these are of a size

*Statement by Dr. A. J. Lanza, in the report of a symposium under the sponsorship of the Department of Preventive Medicine, Medical College of Virginia, Richmond, September 12-13, 1940. *Industrial Medicine*, November 1940, p. 559.

**Houlton, Ruth. "Nursing Service for the Small Plant." *PUBLIC HEALTH NURSING*, September 1939, p. 515.

***"Public Health in the National Defense Program." *Public Health Reports*, September 27, 1940, p. 1761.

which can be adequately served on a part-time basis seems a logical first step. The local chamber of commerce can give helpful information. The staff nurses of the agency will be familiar with industries in their various districts and should be able without undue expenditure of time to secure information about the health services already set up within these industries and the number of workers employed. Information concerning health hazards peculiar to the various industries is also important to have as a basis for plans when offering services. When the association has discovered the industries in the community for which part-time nursing would seem useful and something about the special health needs of each, it must next plan its campaign. A number of factors must be considered.

ADEQUATE NURSING STAFF

Though the cost of industrial nursing will be paid by the industries served, there is likely to be some expense in initiating the program. For this reason, not only should the agency board understand and support the plan, but it should be explained to those responsible for community chest budgets or other sources from which funds are secured for free service to those unable to pay.

Sufficient nursing staff must be available so that this new obligation can be met without taking essential nursing time from the already existing agency program. Another important factor to be considered is preparation of the nursing staff for the new service. At least one member of the staff should have experience in industry. By good luck, such a nurse may already be employed or perhaps can be appointed when a vacancy occurs. Often it will be necessary, however, to select well prepared, capable, staff nurses who are thoroughly familiar with community resources, and arrange leaves of absence during which they may secure experience in the indus-

trial field. This preferably should be in the state where the community is located because a working knowledge of the workmen's compensation act in her own state is an important part of the equipment of an industrial nurse.

In addition to field experience, these nurses will profit by the opportunity to observe industrial nursing as conducted on a part-time basis by a visiting nurse association. One public health nursing agency in preparation for industrial contracts has recently given three of its nurses an opportunity to secure industrial experience at its own expense, and is making plans for others. Several of the nurses selected for this experience have already completed a program of study in public health nursing which includes industrial hygiene courses.

In addition to proven ability in the general public health nursing field and special experience in industry, nurses selected for this service need to be able to make effective contacts with adults of varying abilities and interests. Industrial nursing differs in this way from most types of public health nursing. The nurse in industry deals almost entirely with adults.

MEDICAL APPROVAL

Medical approval of plans for industrial nursing must be sought. It is customary for visiting nurse associations to ask approval for new undertakings from their medical advisory committees, which in turn interpret such projects to the medical profession of the community. It would also be courteous to discuss the plan with the local health officer.

Then, too, the Council on Industrial Health of the American Medical Association is now suggesting the formation of a committee on industrial health in each county medical society. Such a group could give a great deal of help to the visiting nurse association from the beginning, in planning for contracts with industry.

When it is decided to make an approach to a particular industrial concern, the "salesman" for the plan must be carefully selected and must be armed with information concerning the people responsible for the plant's management, the employees who do the work, and the health conditions and hazards of that particular industry or commercial organization. Insurance companies can give expert advice on selling the industrial nursing program since they are familiar with the cost of accidents, hazards involved, and first-aid and medical service needed. They understand the need and will be strong backers of such programs. The industrial hygiene divisions of state and city health departments are also sources from which expert advice can be secured.

Increasingly, industrial management and industrial workers are aware of the importance of the health service, and the suggestion of a way by which nursing service can be obtained may receive an immediate response. Often, however, the idea will be new both to the employer and his employees, and the offer must be accompanied by a well thought out plan with suggestions for the program of service and an estimate of the charge to the industry for definite units of nursing time. It is well to have a written statement of the tentative plan to leave with the official interviewed.

Different appeals must be used with different industries. Some will want visits in the home as well as service in the plant. Experience has shown that it is wise to anticipate some of the questions employers will ask. They will possibly question the withdrawal of a nurse from her needy patients. They will ask if they may have the same nurse all the time. They will want to know what sort of a report they may expect on her work. Stress may be placed on the fact that the visiting nurse association can provide qualified substitute nurses in case of illness and vacations,

since this is a point that presents difficulties in plant production and is therefore appreciated.

The Committee on Healthful Working Conditions of the National Association of Manufacturers estimates that at least two hours of nursing time a week are needed for each 100 employees in an industrial plant. The Visiting Nurse Society of Philadelphia, however, has found that in certain hazardous industries the amount of time needed is at least four hours a week for each 100 workers. Service should be provided on every working day, if at all possible.

CHARGES FOR THE SERVICE

Charges for nursing service are worked out to cover the cost of the nurse's time in the plant, relief for vacations or during illness, and necessary supervision and clerical help given by the agency. The cost is usually estimated on a time basis similar to that for appointment nursing service in homes. After the cost is estimated, however, it may be wise to make a monthly charge, as this is often more acceptable to employees and to management. A written contract specifying the time for which the industry agrees to pay and the amount of payment required by the agency should eventually be signed by both parties to the agreement after details are decided upon.

Duties of the nurse will vary with different types of industries. She will be available at definite times, convenient to the industry, for treatment of minor injuries, individual conferences on health problems, assistance to the physician in making health examinations, and assistance to the employee in planning for the correction of defects through referral to the family physician, or, when necessary, to clinics. The nurse will work closely with the safety committee of the plant. She may render assistance in plant housekeeping, supervise rest-rooms, and perform other duties as required. Some plan for medical direction

of the nursing service must be made. Written standing orders to be used by the nurse in the doctor's absence will be signed by the responsible physician.

If the first contract with industry

gives satisfaction, service can more easily be extended to other concerns. Hence, careful preparation and planning for this first industrial nursing service are of great importance.

ASSISTANCE TO NONCITIZENS

PUBLIC HEALTH nurses giving service to families in which there are non-citizens may be asked for advice or help in regard to their registration under the Alien Registration Act. According to this law all aliens must register between August 27 and December 26, inclusive, at a first class, second class, or county seat post office.

Social agencies throughout the country are coöperating with the Director of Alien Registration in giving help to noncitizens with problems and questions that arise in connection with registration; in preventing the exploitation of aliens; in preventing the attachment of any stigma to registration; and in protecting the welfare of aliens insofar as possible.

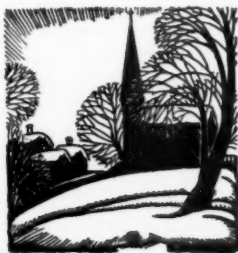
Patients who are noncitizens and who ask for help with problems arising out of registration should be referred to the local social agency which is assuming responsibility for giving such assistance—just as they would be referred for help with any other social problem.

If an alien is bedridden, either in his home or in a hospital, the local postmaster should be notified by the family. The postmaster is responsible for making arrangements for the registration. It is important that noncitizens be informed that registration is free; that they may register without aid if they wish, in a postoffice of their own choosing, in their own or another community or state; that they can obtain assistance from reputable agencies without charge; and that they are not required to answer the call of any voluntary agency, organization, or employer to register or to obtain assistance in registration.

Specific questions in regard to registration are answered in the following pamphlets:

A Manual of Information for Aliens and Those Advising Them. Common Council for American Unity, 222 Fourth Avenue, New York, N. Y. 15c.

Questions and Answers on Alien Registration. Immigration and Naturalization Service, United States Department of Justice, Washington, D.C.



"Let's Do Something About Camp Nursing"

BY ETHEL RYCKMAN, R.N., AND NINA LEVERING, R.N.

These steps by which local nursing and camp groups became interested in improving the nursing service in summer camps offer suggestions for coördinated effort

"WHY DON'T we do something about it?" chorused the three of us who were seated together at a public health nursing dinner. We had been talking about camp nursing, and had asked ourselves various questions: "Why are so few nurses interested in camp nursing?" "Why don't more camp directors consider their nurse a health counselor?" "Why do so many camp nurses think only of first aid and the care of the sick?"

Our interest in this situation grew out of personal experience with children's camps and the problems raised by students in the Western Reserve University school of nursing. At the suggestion of a local nursing educator we three became a special Committee on Camp Nursing* in the spring of 1939. One of our members had served on the local camp standards committee, and her first-hand knowledge of problems greatly facilitated the formulation of our plans which are described here.

PRE-CAMP CONFERENCE HELD

A pre-camp conference for camp nurses was arranged by the committee early in June. Announcements were sent to the directors of the various hospital and public health nursing staffs. The secretary of the camping organization notified the camp directors about the conference. Fifteen nurses partici-

pated in the discussion of a healthful camp environment, health activity program, and staff relationships. A bibliography on camp nursing was given to each member and reprints of an article, "The Nurse Goes to Camp,"* were sold.

This encouraging response stimulated the committee to meet the group's request for a post-camp conference in September. Only two nurses reported. Some forgot the date because notices were not sent and others were unable to be off duty at the time of the meeting. It was suggested that another conference be planned for May 1940.

VARIOUS AGENCIES PARTICIPATING

The American Camping Association was brought into the picture at this point. During the winter the committee made contacts with key members of the Organization Division** of the Lake Erie Section of the Association to interpret our plans and to offer our assistance in improving camp nursing. The chairman welcomed this offer and suggested that the committee prepare some recommendations on camp nursing to submit to the camp directors at a spring meeting.

After some tentative recommendations had been drawn up, the committee consulted with the chief of food and drug administration of the Division of Health, The Cleveland Department of

*The Committee was comprised of the authors and Hanna Buchanan, director, The Children's Fresh Air Camp and Hospital, Cleveland, Ohio.

*St. Clair, Lulu. "The Nurse Goes to Camp." PUBLIC HEALTH NURSING, April 1939, p. 209.

**This Division serves as the camp council in The Welfare Federation of Cleveland.

Public Health and Welfare. As a member of the local camp standards committee, he had prepared "Camp Sanitation Suggestions," which were accepted as a standard for the local camps. This public official gave us valuable assistance in many ways.

The interest and support of a representative nursing group were needed at this stage. The Central Committee on Nursing in Cleveland* was informed of our work, and they appointed a lay and professional committee on camp nursing to work with us. In April its lay chairman and the secretary of the Central Committee on Nursing attended the meeting of the camping organizations, when our little committee of three presented its suggestions for consideration.

These suggestions, mimeographed under the title of "Information for Camp Directors Employing Camp Nurses," were favorably discussed at the meeting. Although the suggestions were not formally accepted as standards, the group expressed its appreciation and agreed to include some standards for nursing in the proposed revision of its camp standards manual. The plans for the second nursing conference in May were announced and the camp directors expressed their willingness to cooperate with publicity and participation.

Plans for this conference and the problem of placement of camp nurses were discussed at a meeting of the two committees working on camp nursing. It was decided that the small camp nursing committee of three would continue to be responsible for the conference for camp nurses, and that the secretary of the Central Committee on Nursing would serve as placement secretary and make some suggested changes in her committee's application form to adapt it to the needs of camp nursing.

The "Information for Camp Directors

Employing Camp Nurses" was given the endorsement of the Central Committee on Nursing and copies were sent to the organization of camp directors, the chairman of the local organization of private camps, and other interested people in the community. The Committee offered the organization of camp directors the services of its secretary as a clearing house for calls for camp nurses.

SECOND CAMP NURSING CONFERENCE

The role of the nurse in the total camp program and her relationships with other members of the camp staff received special emphasis at the second camp nursing conference. The discussion leaders were the chairman of the camping organization; the local food and drug administrator who had prepared the manual on camp sanitation; a representative of the lay parent group; two experienced camp nurses; and a senior student nurse, who had previously been a camp counselor and planned to do camp nursing. The conference was attended by seventeen camp nurses, one camp director, and nine other persons who were interested in the improvement of camp nursing.

All requests for camp nurses for the summer were filled by the secretary of the Central Committee on Nursing, and with few exceptions, the nurses who were appointed had attended the conference.

It is hoped that future nursing conferences can be conducted as a part of the general pre-camp institute for directors and counselors, which is held by the organization division of the local camping association in cooperation with the group work course of the university.

The three members of the small committee were invited, through the American Camping Association, to attend a three-day seminar on "Health, Safety, and Sanitation in the Summer Camp," sponsored cooperatively by the W. K. Kellogg Foundation and the Michigan Camping Association, and held at the

*See "Coördination of Nursing Resources in a Community," by Josephine Smith, *PUBLIC HEALTH NURSING*, July 1930, p. 369.

Foundation's Pine Lake Camp. We came away feeling that camp directors need to be made more aware of what constitutes good camp nursing and hoping that more qualified nurses will become interested in preparing themselves to meet the new demands.

The suggestions of the committee are published here in the hope that they may serve as a point of departure for

further efforts to define functions and set professional standards in this phase of nursing. Our experience would indicate that local nursing groups can make a definite contribution to this field. It is important to begin early in the fall making plans for the coming year, and effective efforts depend on the coordination of all those interested in summer camps.

INFORMATION FOR CAMP DIRECTORS EMPLOYING CAMP NURSES

These suggestions are prepared by the Committee on Camp Nursing cooperating with the Cleveland Central Committee on Nursing and the Organization Division of the Lake Erie Section of the American Camping Association.*

FUNCTIONS OF CAMP NURSE

The functions of the nurse depend upon the kind of camp, the type of camp program, and the number and ages of children who are cared for. The nurse:

1. Assists in planning the general camp program.
2. Participates in the precamp conference of camp personnel and in regular staff meetings during the camping period (a) to interpret the place of health in the total program (b) to coordinate nursing with other camp activities.
3. Participates in formulating and developing a health program based on the needs of the campers and staff.
4. Contributes to the maintenance of a healthful camp environment—physical, emotional, and social.
5. Assists physicians in the examination of campers and in the interpretation of findings to staff, parents, and children.
6. Teaches the value of health supervision and the use of facilities for medical and nursing care and assists in securing correction of defects.
7. Encourages and instructs staff, parents, and campers to observe and recognize deviations from normal health.
8. Teaches health education classes at camp except those taught by a physician or nutritionist.

*Slight modifications have been made in these suggestions in order to make them generally applicable.

9. Assists in the control of communicable diseases through teaching the recognition of early symptoms, the importance of isolation, and the value of immunization.

10. Arranges for the care of injuries and illnesses in accordance with policies established by the camp director, who is responsible for securing such medical regulations in writing for the direction of the nurse.

11. Keeps adequate health records—recognizing physical, emotional, and social factors. Prepares a final report for the director, including recommendations for follow-up of individual children and for future camp health programs.

12. Checks medical equipment and supplies and submits to the director a list of those needed for the season. Prepares an inventory of medical equipment and supplies for the director at the close of camp.

QUALIFICATIONS OF CAMP NURSE

1. Desirable personal qualifications include: good health, good health practices, an interest in and liking for children, an interest in outdoor life and camping, the ability to work well with others and adjust to camp environment, the ability to recognize and utilize opportunities for health promotion, a sense of humor, good judgment, emotional stability, and an appreciation of and cooperation with camp philosophy and the aims of the organization.

2. Educational qualifications include general and professional preparation. High-school graduation or its educational equivalent is important, and more advanced education on a college level is desirable. Graduation from an approved school of nursing and state registration are essential. Postgraduate work which is especially helpful includes an approved program of study in public health nursing, a course in growth and development of children, a course in child psychology, and a course in camp administration and program.

3. Any or all of the following types of experience are valuable: undergraduate student affiliation in public health nursing, public health nursing staff experience, school nursing experience, and experience as camper or camp counselor.

SALARY FOR CAMP NURSE

\$70 to \$90 a month plus room, board, and laundry—if uniforms are required. (These are based on the average salaries—\$120 to \$140—of public health nurses in the Lake Erie District.)

UNIFORM FOR CAMP NURSE

The nurse's uniform may be desirable for

identification purposes on such special occasions as the opening day or visiting hours. A public health nursing uniform is preferable to white.

A three-piece play suit is appropriate unless the camp has a regulation uniform for counselors.

TIME SCHEDULE

Because of emergencies, the camp nurse must be available twenty-four hours a day except when relieved for time off. The director should plan adequately qualified relief for the nurse for meals, for special meetings of the camp council, and for the usual time off arranged for all counselors.

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THE AMERICAN JOURNAL OF NURSING FOR DECEMBER

Preparing for Delivery at Home

It's Good of You to Want to Help!.....Lona L. Trott, R.N.

Opportunity in the Army Nurse Corps

Suction Siphonage Modified.....Helen E. Penhale, R.N., and James Spearman, R.N.

Simplifying Hypodermic Injections

Thelma Dodds, R.N., Lucile Petry, R.N., and Charles A. Koepke

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Nursing in Sweden.....Majsa Andreell

Gifts for the Sick

Nursing Education and National Defense.....Isabel M. Stewart, R.N.

Student Aid—Scholarships and Loan Funds.....Ruth K. Moser, R.N.

Job Satisfaction in Nursing.....Helen Nahm, R.N.

Prepayment Plans---Applicable to Nursing?

By DAVID H. McALPIN PYLE

The possibility of financing nursing care in the home through prepayment plans is discussed by a writer who has had long experience with such plans

HOW ARE public health nursing services to be financed in the future? This is an important problem confronting nursing organizations today. It is the purpose of this paper to discuss the need and the opportunities for the financing of your work in what will, I believe, be a new health era. There must be such an era if we are to go forward toward a practical utilization of the scientific forces which have been developed.

For six years I have given my full time and energy to studies of the health field, particularly as it relates to the situation of organized institutional care of the sick in New York City. Those studies of a system bound with the chains of outworn tradition and at times clouded and haphazard thinking have not always been encouraging. The one bright light which gives us the will and the strength continuously to review it is the knowledge that this system is changing.

NEEDS OF THE FUTURE

Our system of providing health care is not criticized here for what it had done in the past. But I question its ability to serve the needs of the future. Those needs have been sharply defined. So too have the weaknesses of our present system been defined.

Progress of the health sciences in the past several decades is without precedent. You are fully aware of that progress. You have taken part in it. You have seen the new horizons of health made possible by the x-ray film, radium, sul-

fanilamide, insulin, and countless other comparatively recent discoveries. You know of the vast improvements which have been made in the education and training of health workers, particularly those in the nursing field.

Yes, we have created a powerful machine of science. But somewhere along the way we have failed; because that machine of science has too few conduits leading to the homes and lives of the people. Our great diagnostic, curative, and preventive powers are not as yet adequately serving the purpose for which they were intended.

Health care, as we would like to define health care, has by reason of its progress become an expensive commodity. Scientific training and equipment are costly. Our machine of science is the best in the world. But it is a necessity with a luxury price for most of the people. We have not as yet succeeded in bringing it to the people for whom it was designed. We have not succeeded because in the support and maintenance of our health services we have not kept pace with developments in the science of those health services.

The chief sources of support of our voluntary hospitals, for example, are contributions from the public, income from patients who are able to pay, income from endowments and investments, and government payment for the care of public charges. Those sources of income today are not adequate as a foundation for a future program of expansion.

And there are indications that those sources of support coming from generous givers will not be as dependable in the future as they were in the past. The tax burden on incomes and estates is being increasingly felt.

NONPROFIT PREPAYMENT PLANS

In the past few years, nonprofit hospital service plans have given proof that the American people do want to protect themselves, and that by acting together in a democratic plan of cooperation, they may secure at low cost the benefits of at least one essential health service through the application of sound actuarial principles. Nonprofit hospital service plans have successfully utilized the principle of insurance to provide protection against the unpredictable costs of hospital care.

Today there are sixty approved nonprofit plans in key cities and communities throughout the country with an enrollment of about 4,500,000 persons. Under each of these plans, certain specified hospital services are provided by the participating hospitals to the subscriber. In return for those services, the hospital receives payment from the hospital service plan.

Nonprofit hospital service plans have successfully demonstrated that groups of persons joined together for the protection of all can obtain benefits for a smaller cost to the individuals in the group than would be possible under any system of individual payment. This is not, in reality, a new principle. It is a new application of an old American principle that has stood behind the advance of this democracy. By working together, the American people have solved many a problem.

In addition to the assistance to the subscriber, or user, the nonprofit hospital service plan also has given proof of its value as a dependable source of income for the service renderers—in this instance, the hospitals. In the metro-

politan area of New York City, Associated Hospital Service has paid the hospitals more than \$18,000,000 for the care of subscribers within a period of five years. We are now paying at the rate of about \$8,000,000 a year.

PROVING GROUND FOR TOMORROW

Here we have a proving ground for tomorrow. Here we have evidence that the prepayment service principle of providing health benefits is practicable. It works. It is not a dream or a theory. It has been successful during the most difficult days of our financial history.

I do not say that the nonprofit hospital service plan as it is today offers more than a partial solution to the problem. I do believe, however, that a voluntary prepayment method of providing a broader and more economical distribution of health service is not only a possibility but a necessity of the future.

In New York, hospital service plans are permitted by law to offer only one type of service. *Ipso facto* it has as yet little relation to the nursing profession. We are, however, preparing ourselves and working to hasten the time when the plan may offer a more complete program of health service.

CARE OF SICK IN HOME

The nursing profession holds one of the keys to care of the sick in the home. Much has already been done in that field, but you will agree that in view of its possibilities it is still in its infancy. There is need for a greater understanding of that service, an understanding that will create the ever-essential popular demand and the means of bringing it within the reach of all.

Here one may see the field of opportunity for a closer relation between the nursing profession and the hospital service plan. The time is near when the people of this nation, by popular mandate, will cause the extension of the voluntary prepayment method to include more than institutional care. The

time will come when the public itself will tear aside the veils of tradition and develop the plan so that all health services will be made available to them at a price they can afford to pay.

The whole question of public health today awaits the full development and extension of our present diagnostic and curative services into a larger and more fundamentally essential field of preventive service through wider use and earlier availability.

The voluntary prepayment plan of financing health services can, if permitted, be extended to include a wide field of health needs. Nursing service in the home, bringing knowledge and skill into the homes of the people, could then be expanded on a sound financial basis. In the past we have depended too much upon a small group of people for the support of such services with consequent limitation of the number served. By widening the opportunity for the people to protect themselves at low cost through the principles being developed in the prepayment service plans, the door will be opened to the utilization of this opportunity.

HOME CARE RELIEVES HOSPITALS

We in the hospital field are particularly interested in the extension of nursing services. With the further development of home care the hospitals will be relieved of much of their present burden. Patients who do not actually require institutional treatment, but who now have no other way of obtaining treatment, will be cared for in their homes at a considerable reduction in the cost of care and without loss of quality of service. For do not let us forget that institutional care is a costly service and able only to meet a part of the health needs and problems of the nation.

Health is this nation's chief problem today. We who are aware of developments in the health field cannot ignore

that. It rests today on our own front doorstep and the opportunity is open to our country to advance into new fields of health service.

The extension of the voluntary prepayment principle cannot be accomplished as easily as it is stated. There will be opposition, most of it founded upon traditional beliefs. Developments of the past, however, should be guides, not rules, for the future. We live in a changing world. We too must be prepared to change, and we must plan that change so that we will retain the elements of democracy. The self-protection made possible by the group prepayment method of obtaining health care encourages the spirit of democracy as well as develops individual freedom from dependence upon others.

WOMEN SHOULD GIVE LEADERSHIP

Our success will be the more certain and the more rapidly attained if the women of the nation will move with vigor to extend the principle that the people themselves can support in ever-increasing measure their own health protection and if our women will be leaders in the education needed to bring about an ever-widening use of protective health provisions.

In every community where there are board members of a nursing organization, there are potential spokesmen for you in that community's hospital service plan. Arouse their interest. Encourage them to enter into the extension of the service into your field. Your voice is a necessary voice on the boards of directors and in the administration of hospital service plans throughout the nation. You can play a great part in the future development of these plans which are so closely related to your own hopes for tomorrow's health services.

Presented before the N.O.P.H.N. Round Table on Earnings in Public Health Nursing Agencies, Biennial Convention, Philadelphia Pennsylvania, May 14, 1940.

Social Security and the Nurse

Nurses will want to be informed of insurance "benefits" available to them or their patients under the Social Security Act and of aid available to needy patients

THERE ARE under the Social Security Act two social insurance systems for men and women who work for wages or salaries. Under these systems the nurses employed in business and industrial plants are now building up an income for their old age, and protection against unemployment in the meantime. Bills now pending in Congress would extend this insurance coverage to employees of non-profit institutions, including hospitals, public and private, to employees of other state, county, and municipal institutions, and to private duty nurses as well.

There are also, under the Social Security Act, far-reaching programs of public assistance to the needy, many of whom as patients come within the nurse's round of duty. Thus social security programs touch the professional life of a nurse, as well as her personal fortunes.

OLD-AGE AND SURVIVORS INSURANCE

The old-age and survivors insurance system under the Social Security Act provides a monthly retirement income after the age of 65 for men and women employed in business and industrial establishments, large or small. It pays monthly benefits also to the worker's wife, widow, children, and orphans, or dependent parents.

The benefits are computed as a percentage of average monthly salary, in employment covered by the Social Security Act, up to an average salary of \$250 a month, plus credits for length of service. They are computed by the Social Security Board when the claim comes due, from records kept by the Board.

These records, for every wage or

salary worker under the system, are taken from wage reports furnished to the government by employers every three months. Each item of wage or salary is posted to the individual social security account of the worker to whom it was paid. Every account has a number for identification purposes, and the worker is furnished with a social security account card bearing his or her name and account number. This number in turn is reported by the worker to the employer, whose records must show both the name and number of every person on his payroll.

To be eligible for retirement benefits after the age of 65, the worker must have received at least \$50 in wages in each of a certain number of calendar quarters; that is, in half as many quarter years as have passed since January 1, 1937, when this insurance system was started, and before the quarter in which he attains the age of 65. In any event, he must have credits of \$50 or more in each of at least six quarters. But with as much as forty such quarters to his credit any worker is qualified to receive monthly benefits at the age of 65, or for his family to receive monthly benefits in case of his death. If he leaves a widow with young children in her care, six quarters of credit, if they fall within the last three years before his death, are enough to entitle the widow and children to benefits.

Old-age and survivors insurance is a contributory system. Employers and employees share the cost by paying a

NOTE: This material was furnished by the Bureau of Informational Service, Social Security Board, Washington, D.C.

tax on the employee's wage or salary. The tax money goes into the federal treasury. An Old-Age and Survivors Insurance Trust Fund has been established for payment of benefits as claims become payable. This trust fund is maintained by annual appropriations equal to 100 percent of the taxes collected.

There are fifty-odd million social security accounts on the books of the Social Security Board, and monthly benefits have been payable since January 1, 1940. Many thousands of men, women, and children are now receiving such payments and the numbers will grow, of course, as more workers reach retirement age.

Most of the old-age benefit payments so far fall between \$20 and \$40 a month. For a man and his wife, when the wife is also 65 years old, this means \$30 to \$60 a month, because a wife's benefit is equal to half the amount of her husband's.* For a child the monthly benefit is half the amount of the parent's. A widow of 65, or a widow at any age, if she has young children in her care, receives three-fourths of her husband's benefit. A widow without children who is less than 65 years old receives a lump sum at the time of her husband's death, and widow's monthly benefits from the time she is 65, provided she does not marry again.

How these benefit payments work out may be seen in the case of a nurse who was 35 years old when the insurance system was started on the first of January 1937. If her average salary has been \$150 a month, her monthly benefit, if she retires at the age of 65, will be \$30.90. In case of her death, if she is the sole support of her mother or father, or both of them, each parent after the

age of 65 will receive \$15.45 a month.

UNEMPLOYMENT INSURANCE

The unemployment insurance system pays weekly benefits to unemployed workers who meet the requirements of the law, to tide them over until they can again get work.

It is a federal-state system, provided for in the Social Security Act, but requiring state action to become effective within each state. Every state now has its own unemployment insurance law, however, and a state unemployment fund out of which to pay benefits. The fund is made up of contributions required from payrolls of employers—in a few states from employees also. If the state law conforms to requirements of the Social Security Act (as all of them do) the Federal Government pays the costs of administration.

Eligibility for out-of-work benefits depends upon earnings during a "base period" which is usually a year, but the state laws differ on this. Benefits amount to about half pay, with maximum benefits of \$15 to \$18 per week, and the eligible worker may receive his weekly benefits for a period of 12 to 20 weeks (depending on the state law), provided he is unable to get a job meanwhile.

To apply for out-of-work benefits, the worker must first register for a job at the nearest state employment office, of which there are 1500 throughout the country on full time, and over 3000 places where part-time service is given.

The employment office requires, of course, that the applicant for a job and for unemployment insurance shall report back to that office at frequent intervals. If no suitable job is found within a waiting period of two or three weeks (depending on the state law), the benefit period and the benefit payments begin.

Like the federal unemployment insurance provisions, the state laws cover employees of business and industrial establishments. Some states follow the

*If the wife is a wage earner herself and as such entitled to a benefit on her own account, she receives either that or a wife's benefit, whichever amount is larger. She cannot receive both.

federal provisions and limit the coverage to firms employing eight or more persons. Others extend coverage to smaller firms and in some states employers of one or more are covered. Nurses employed by business or industrial establishments with the number of employees stipulated in the respective state law are covered by unemployment insurance as are other employees of such firms. So far, however, the laws do not cover employees of public service or non-profit institutions, nor do they cover agricultural labor, or domestic service. Such extensions are proposed, however, in bills now pending in Congress.

THE PUBLIC ASSISTANCE PROGRAMS

There are three public assistance programs under the Social Security Act. They are administered by the states, with the Federal Government sharing the cost. Each of these programs provides a monthly allowance to persons in need, in order to enable them to live at home.

This help is now given in all the states to needy men and women over 65 years of age; to needy blind people of any age in 41 states, Hawaii, and the District of Columbia; and to dependent children under 16 (or 18 if they are regularly in school) in 41 states, Hawaii, and the District of Columbia. The remaining states have not yet undertaken to join in the federal-state program for the children and the blind. But there are in all nearly three million recipients of public assistance under these programs.

Application for help of this kind is made to the nearest public welfare office, which investigates each case. The amount of the monthly allowance for each applicant is determined by the state according to the need found in that particular case, and according to the state's own standards of assistance.

Eligibility requirements vary somewhat from state to state, but most states

require citizenship for adult applicants, and at least a year of residence in the state just before the application is made, with usually four more years of the last nine. For children there is no question of citizenship, but ordinarily the mother of a child less than a year old must have lived in the state a year.

For the old and the blind the Federal Government pays half of any allowance the state may grant, up to \$40 a month; that is, the Federal Government will pay as much as \$20 a month if the state pays \$20 or more.

For children the Federal Government will pay half, up to a total allowance of \$18 a month for the first child, and up to \$12 a month for each other child in the same home. These allowances are payable only for children in families which have lost their breadwinner, and where the children are cared for by a parent, grandparent, sister, brother, aunt, or uncle. The purpose of these allowances is to keep the family together.

Nurse and patient both, then, may have a stake in the Social Security Act. This sick old man, for example—has he been working since 1936? Is he perhaps eligible for old-age insurance benefits but doesn't know it?

Or poor old Mrs. D. She and her husband have nothing left but the house they live in. Could this old couple get an old-age assistance allowance? And this blind woman, or this overworked mother of a family of fatherless children—surely they could get the help the state and the Federal Government provide under the public assistance programs, if they knew how to go about it.

The nearest welfare office will know—and the nurse can point the way.

Published in *The American Journal of Nursing*, December 1940. Pamphlets explaining the Social Security Act and giving information on the various benefits are available free of charge upon request from the Social Security Board, Washington, D.C.

Public Health Workers Meet in Detroit

THE ENTHUSIASM shown at the Seventh Institute on Public Health Education which preceded the Annual Meeting of the American Public Health Association in Detroit was only one index of the success of the meetings. As usual, several other organizations took the opportunity to meet, and the visitor was constantly torn in making a selection from among the meetings so ably planned by the various groups and sections.

On the Sunday and Monday preceding the formal opening of the meeting on October 8, a group conference on orthopedic nursing was conducted by Jessie L. Stevenson, assistant director of the National Organization for Public Health Nursing. After hearing Miss Stevenson's graphic discussion of posture, one wonders why, even in hospitals, two pillows are usually provided instead of one or three, either of which is much more desirable in the maintenance of normal posture!

Except for two meetings concerned with Section reports, the Public Health Nursing Section of the A.P.H.A. had joint meetings with other sections. One of the most interesting sessions was held with the Industrial Hygiene Section. Various problems and opportunities with which the nurse in the small industry is faced were presented by Victoria C. Stralko, Ruth W. Hubbard, and Dr. T. Lyle Hazlett. These papers were discussed by Dr. Donald M. Shafer, after which Dr. Russell B. Robson presented a paper on "Health Maintenance in a Group of Small Industries."

Other joint sessions were conducted with the American School Health Association, the Oral Health Group, and the Food and Nutrition Section.

Some of the highlights included the reports of the Committee on Administrative Practice of the A.P.H.A., in which

were incorporated recommendations on administrative measures for the prevention and control of diphtheria, measles, whooping cough, tuberculosis, and scarlet fever; and reports of studies in the Epidemiology Section on Observations in the familial incidence of cancer, and on factors in the occurrence of rheumatic fever. A public hearing on Anytown School Health Budget presided over by Dr. Reginald M. Atwater as mayor resulted in cooperation between the health department and the school board to the extent that the health services were administered by the health department and the nursing service became generalized.

An entire session on October 11 was devoted to the various aspects of the prevention and care of rheumatic heart disease in children. Dr. T. Duckett Jones, research director of the House of the Good Samaritan in Boston, summed up his preference for the care of chronically ill cardiac children in institutions as follows: (1) Better education is possible on how to convalesce. (2) Better mental hygiene results from seeing other children in the same condition. (3) It is easier to teach a group than an individual to face possible permanent adjustment to limitations throughout life. (4) It is easier to help children keep up in their regular school work. (5) It is usually easier for the family. (6) It provides an opportunity for teaching medical students. (7) It provides an opportunity to experiment with treatments and check results. (8) Parent classes held before children are discharged to their homes facilitate the transition.

The well planned technical and scientific exhibits and the many educational motion pictures provided interesting features of the meeting. The presentation of the 40-year membership certifi-

cates was a high spot of the annual banquet on Thursday evening. Of course, the event of the week for public health nurses was the dinner given in honor of Grace Ross and described in the November issue of PUBLIC HEALTH NURSING (page 663).

In a lighter vein, mention should be made of the broadcast of the Ford symphony concert, the tea arranged under the auspices of the women's entertainment committee, a tea for executives and board members of public health nursing organizations given by the Board of Directors of the Detroit Visiting Nurse Association and Detroit Council on Community Nursing, and the many inspection trips to laboratories and other points of interest in and near Detroit.

A note of sadness was injected into the opening general session on the evening of October 8 when Dr. Milton J. Rosenau awarded the 1940 Sedgwick Memorial Medal posthumously to Dr. Hans Zinsser. Dr. Rosenau expressed Dr. Zinsser's readiness for "the great adventure" by reading a poem Dr. Zinsser wrote soon after he realized the probable brevity of his life. In a few well chosen words Dr. Haven Emerson accepted the award for Dr. Zinsser's family.

The officers elected for the coming year are:

President—W. S. Leathers, M.D., Nashville, Tenn.

President-elect—John L. Rice, M.D., New York, N. Y.

First vice-president—Robert D. Defries, M.D., Toronto, Canada

Second vice-president—Carlos E. Finlay, M.D., Havana, Cuba

Third vice-president—Selskar M. Gunn, New York, N.Y.

Treasurer—Louis I. Dublin, Ph.D., New York, N.Y.

Chairman of executive board—Abel Wolman, Dr.Eng., Baltimore, Md.

Executive secretary—Reginald M. Atwater, M.D., New York, N.Y.

The new members of the Governing Council are:

M. E. Barnes, M.D., Iowa City, Ia.

A. Grant Fleming, M.D., Montreal, Canada

Leslie C. Frank, Washington, D.C.

Ira V. Hiscock, Sc.D., New Haven, Conn.

A. Parker Hitchens, M.D., Philadelphia, Pa.

Pearl McIver, Washington, D.C.

Roy J. Morton, Nashville, Tenn.

J. T. Phair, Toronto, Canada

Samuel C. Prescott, Sc.D., Cambridge, Mass.

Felix J. Underwood, M.D., Jackson, Miss.

The officers of the Public Health Nursing Section are:

Chairman—Ruth Houlton, New York, N.Y.

Vice-chairman—Laura A. Draper, Minneapolis, Minn.

Secretary—Helen Bean, Lansing, Mich.

The next convention will be held in Atlantic City, N.J., in the fall of 1941.

A. G.

A GUIDE TO THE SCHOOL NURSE

What is a sound dental health program in the school? Page 732.

What should be the school regimen of the child with rheumatic heart disease? Page 711.

The school nurse is interested in summer camps. Page 744.

The nurse and social worker join efforts to achieve the treatment and rehabilitation of the crippled child. Page 722.

School nurses are asking questions about the call of First Reserve nurses by the army (page 737); and they will participate in the National Nursing Inventory (page 736).

NOTES *from the* NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING



Bachrach

Members of the Executive Committee. Standing, reading left to right, are Dr. Erval R. Coffey, Marion W. Sheahan, Amelia Grant, Laura A. Draper, Dorothy Deming, and Lawrence McLane. Sitting, reading left to right, are Marion G. Howell, Mrs. Frederick S. Dellenbaugh, Jr., Grace Ross, Mary S. Gardner, and Mrs. Charles S. Brown. Absent committee members are Zoe LaForge, Elizabeth P. Taylor, and Dr. W. F. Walker

THE N.O.P.H.N. EXECUTIVE COMMITTEE SMILES

On October 30 the N.O.P.H.N. Executive Committee met in New York City in full attendance with the exception of Zoe LaForge, Elizabeth P. Taylor, and Dr. W. Frank Walker. Matters of considerable importance with relation to National Defense and the N.O.P.H.N.'s share in the program were discussed and referred to special committees and to the Nursing Council on National Defense. But the most encouraging news was the decision to add an industrial consultant nurse to the executive staff

of the national organization in 1941. The Committee undertakes this new responsibility with the hope that it may be a three-year project and that it will meet a current, pressing need in the field of expanding industrial work. There will be a further announcement of these plans in a later issue, but we are sure our readers and members will rejoice that the N.O.P.H.N. finances are in such a sound state that this long-hoped-for development in the field of public health will take place next year.

The Committee on N.O.P.H.N. Personnel Policies reported on our own staff practices, and classified the duties and qualifications for each position along the lines recommended in merit systems. It was suggested that a special committee again explore the problem of a retirement plan for staff members.

A new special committee to study the promotion of pay service by public health nursing agencies was made permanent and is to be enlarged by more representation from the American Nurses' Association. Its members are: Ralph Blanchard, administrative director, Community Chests and Councils, Inc.; Mary E. G. Bliss, assistant director of headquarters, American Nurses' Association; Henry G. Clark, president, the Providence District Nursing Association; Dr. Iago Galdston, secretary, Medical Information Bureau, the New York Academy of Medicine; Mrs. Cooper Howell, formerly president, the Visiting Nurse Society of Philadelphia;

Marie M. Knowles, executive director, Visiting Nurse Association of Brooklyn.

The best news of all concerned the budget for 1941 to be recommended to the Board of Directors in January, which will include the new industrial nursing project. This expense budget of \$118,363.35 will mean that among other hoped-for increases, our membership income will have to be increased by dues from 500 *new* individual members. The Committee approved the recommendation of the Finance Committee to work out a new plan for sustaining members, the details to be left to the Committee.

The Eligibility Committee reported that 207 agencies (56 percent of the number of application blanks sent to official agencies and 62 percent of the number sent to non-official agencies) had returned application blanks for agency membership in the N.O.P.H.N. to date.

DOROTHY DEMING

Secretary, Executive Committee

WITH THE STAFF

Ruth Houlton went to Easton, Pa., on November 15 to give consultation service to the lay groups in that city.

The first six days in November were spent by Evelyn Davis in Alabama under the auspices of the State Department of Public Health. Talks were given in Montgomery and Birmingham to lay committees. She was in Texas from November 8 to 13. She spoke on Lay Participation in Public Health Nursing Education at the joint institute of the S.O.P.H.N. and the State League of Nursing Education in Austin on November 8. The rest of the time was spent with the State Department of Health. Conferences were held and visits were made to counties to discuss lay committee organization. From Texas she went to Alexandria, La., to participate in a panel discussion on lay participation

in organizations employing public health nurses at the annual meeting of the S.O.P.H.N. on the fourteenth. After returning to New York for a few days, she went to Springfield, Mass., on November 20 to speak at the Health Promotion Council luncheon held by the Council of Social Agencies. On the following day, she conducted a discussion meeting for board members at the Springfield Visiting Nurse Association.

Jessie Stevenson conducted an orthopedic institute for Negro nurses at the Meharry Medical College School of Nursing in Nashville, Tenn., on November 12 and 13. She spoke on orthopedic defects in their relation to public health nursing at the annual meeting of the Ohio State Nurses' Association in Columbus on November 15.

Purcelle Peck went to Washington,

D.C., on November 15 to attend the meeting of the National Council for Mothers and Babies.

On November 20, Anna Gring went to Franklin, La., to conduct an institute on school health at the St. Mary Parish Health Center. She went to Fort Worth, Tex., on November 22 and 23 to conduct a school nurses' institute sponsored by the S.O.P.H.N.

Dorothy E. Wiesner gave an institute on records sponsored by the Middletown (Conn.) District Nursing Association on November 13.

HONOR ROLL

The 1940 Honor Roll has broken all previous records! Over 1150 Honor Roll agencies have triumphantly "set the pace" this year and have made it the best Honor Roll year of all times! We are bursting with pride and are sincerely grateful to each one of you who have made this success possible through your individual memberships.

This is the last list to be published in 1940, but there is still time to write in and get your Certificate (if your staff is 100 percent enrolled) and have the name of your staff added to the complete list which will appear in *P.H.N.*, the new N.O.P.H.N. house organ. Won't you help us celebrate this banner year by making sure your agency is on the Roll?

ARIZONA

City of Douglas Health Department,
Douglas
Prescott Anti-Tuberculosis Association,
Prescott

CONNECTICUT

Public Health Nursing Association, Manchester

FLORIDA

Hillsborough County Health Department,
Tampa

Palm Beach County Chapter, American
Red Cross, West Palm Beach

IDAHO

Division of Public Health, Idaho Department of Public Welfare, Boise

INDIANA

Knox County Public Health Nursing
Service, Vincennes

MAINE

*Woman's City Club of Calais, Calais
*School Health Service, Millinocket

MARYLAND

Baltimore County Metropolitan Nursing
Service, Baltimore

MICHIGAN

*North End Clinic, Detroit
Grosse Pointe Health Department, Grosse
Pointe

MINNESOTA

Aitkin County Public Health Nursing
Service, Aitkin

MISSOURI

Cooper County Public Health Nursing
Service, Boonville
State Crippled Children's Service, Columbia
State Trachoma Hospital, Rolla
Miller County Health Department, Tus-
cumbia

NEW JERSEY

*Visiting Nurse Association, Bayonne

NEW YORK

Huntington Public Schools, Huntington

OHIO

Community Nurses Association, Glendale

OKLAHOMA

*Oklahoma City Public Health Nursing
Bureau, Oklahoma City

PENNSYLVANIA

American Red Cross, State College Chap-
ter, State College

TEXAS

Carson County Health Department, Pan-
handle

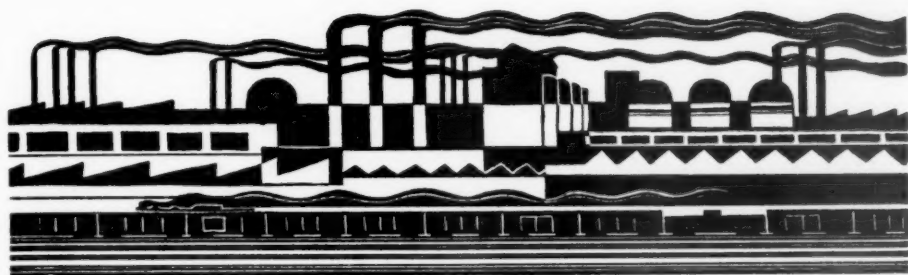
WISCONSIN

Dodge County Health Department,
Juneau
State Venereal Disease Clinic, Superior

ALASKA

Savoonga Office of Indian Affairs,
Savoonga

*Agencies having been on the Honor Roll five
years or more.



IS PART-TIME INDUSTRIAL NURSING FEASIBLE?

CAN PART-TIME industrial nursing services be arranged for small plants through contracts with public health nursing agencies? This question was discussed at the round table on industrial nursing at the Biennial Convention in Philadelphia on May 14, 1940.

A nurse from the Mutual Aid Association in Brattleboro, Vermont, reported that her agency gives a part-time service to one firm at approximately the same rate as that for nursing visits—\$1 an hour.

The nurses of the Philadelphia Visiting Nurse Society answered questions concerning the plan of their agency to give health and first-aid service to five plants. These services vary in time from three to twenty-three hours a week. Nurses for industrial service are carefully selected. They must have a personality suitable for this type of work

and must know community resources. A manual of procedure for the industrial service is now being prepared. Monthly conferences are held in each plant by the industrial physician, the part-time nurse, and the Visiting Nurse Society supervisor. They go through the plants together and later discuss health problems and health hazards. Monthly conferences of the whole group are held at the Society's headquarters. Nurses are not changed oftener than once in two years and the new nurse always acts as substitute nurse first so that she becomes acquainted with employees and with the particular hazards of the industry. Employees needing home visits are referred to the Visiting Nurse Society.

Suggestions for contracts between industries and visiting nurse associations for part-time industrial nursing service are given in an article on page 740.

THE SAFE WAY

A SPEAKER at the home safety session of the National Safety Congress gave as a child's definition of education, "Be able to read the signs at the crossroads and know which way to go." The exhibits, the display of literature, and all the programs at the Congress impressed even a casual visitor that the only way to go is the safe way. How to make the way safe in the home, at school, in the shop, and on

the highway was a challenge to all who participated in the meeting. Prevention was emphasized throughout. The contribution which the public health nurse can make in the recognition and prevention of accident hazards in the home was stressed by W. Graham Cole, director of the Safety Bureau of the Metropolitan Life Insurance Company, New York City.

The necessity for the integration of

safety instruction throughout the school curriculum was emphasized by Mr. G. H. Reavis, director of research of the Cincinnati Public Schools, who spoke at the Child Education Section on "Techniques for Developing and Installing a Program of Safety Education." He stated that such a plan must be comprehensive, extending through all the grades, continuous, worked out in definite sequence, and positive rather than negative. For example, instead of telling children not to stumble over lead pencils, one should keep the pencils off the floor.

Public health nurses were, of course, keenly interested in the sessions of the Industrial Nursing Section. About 250 nurses, physicians, and personnel men attended the Wednesday afternoon session at which Joanna M. Johnson, supervisor of the Industrial Nursing Division

of Employers Mutuals, Wausau, Wisconsin, presided. In a discussion of "New Concepts of Visual Performance in Industry," Dr. Hedwig S. Kuhn of Hammond, Indiana, brought out that data from scientific and practical eye tests lead to safe placement of employees; that the correction of visual defects means the prevention of hazards which may involve others besides the employee; and that visual testing can result in rehabilitation of applicants as well as those already employed.

No follow-up plan to correct defects could be effective without the help of the nurse, according to Dr. O. A. Sander of Milwaukee, who discussed "Follow-up of Findings on Physical Examinations." "Neurosis Following Industrial Injuries" was the subject of a practical discussion by Dr. Lewis J. Pollock of Chicago.



An information booth to give information on the advantages of a nursing service in industry was maintained by Employers Mutuals of Wausau, Wisconsin, at the National Safety Congress in Chicago, October 7-11. One of the organization's staff of nurses was in attendance at all times to answer questions and distribute printed materials

The luncheon at the Stevens Hotel on October 10 was an interesting event, with Mrs. Christian Seabrook, local field supervisor of the Metropolitan Life Insurance Company, Chicago, presiding. The functions of the nurse in industry and desirable minimum qualifications based on those formulated by the National Organization for Public Health Nursing were discussed in Dr. Malcolm T. MacEachern's paper, "An Industrial Nurse's Perspective," which was read by Dr. E. W. Williamson, American College of Surgeons, Chicago.

One could not listen to the two papers which followed without renewed appreciation of the way in which the teaching

service of well qualified nurses in industry affects the health of the entire family: "The Heart and Heart Diseases in Industry," by Dr. J. Roscoe Miller, assistant professor of medicine, Northwestern University Medical School; and "Nutrition for Industrial Workers," by Mary I. Barber, director of home economics, Kellogg Company, Battle Creek, Michigan, and president-elect, The American Dietetic Association. A lively round-table discussion followed on "New Thoughts and Current Problems in Industrial Nursing," led by M. H. Howarth, chief of personnel relations, Teletype Corporation, Chicago.

J. L. S.

PROTECTION OF WORKERS IN DEFENSE INDUSTRIES

A SUBCOMMITTEE on industrial medicine has been set up by the Health and Medical Committee of the Council of National Defense to develop a health program for industrial workers. This subcommittee will work in close coöperation with the Industrial Hygiene Division of the National Institute of Health of the U. S. Public Health Service—a division which is concerned with the coördination of state and federal activities, the promotion of industrial hygiene services in state and local health departments, and industrial health studies carried on in the laboratory and in the field.

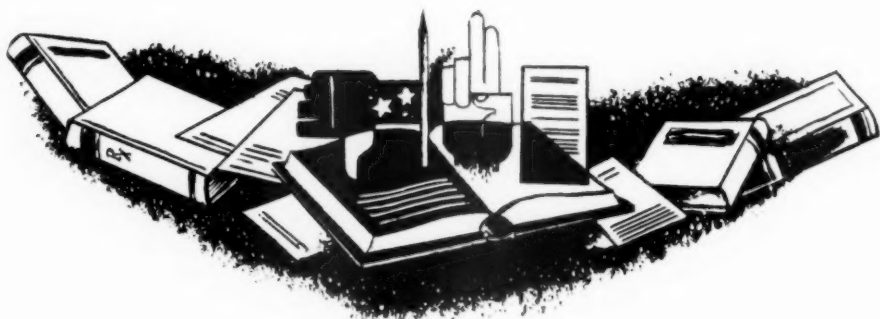
The membership of the new subcommittee includes outstanding industrial physicians and public health authorities representing all parts of the country.

Despite continued improvement, America still has 17,000 occupational deaths from accidents, 75,000 permanent disabilities, and 1,400,000 temporary

disabilities every year, according to the Public Health Service. Protection against exposure to hazardous materials and conditions in industry is far from adequate. And the hazards which already exist will be greatly intensified by the rapid expansion of defense industries, the use of new processes and chemicals whose toxic effects are not known, and the increased turnover of employees due to the departure of young workers for military training.

The Federal Government has been active in the problem of employee health for many years; today 31 states have industrial hygiene units in their state health departments, employing 150 professional personnel skilled in industrial hygiene practice. These units will be utilized to the fullest possible extent in the program which is planned for conservation of the health and safety of workers.

—Summarized from mimeographed release of U. S. Public Health Service, Washington, D.C., November 10, 1940.



EDITED BY ANNA C. GRING

LET'S TALK ABOUT YOUR BABY

By H. Kent Tenney, Jr., M.D. 115 pp. University of Minnesota Press, Minneapolis, 1940. \$1.

Let's Talk About Your Baby is a relief from the stereotyped books which have been written on the subject of infant care. The book takes the form of a series of conversations between the baby, his mother, and his doctor. The content is well selected. The facts are handled with an understanding of the importance of details in the life of a baby—but without sticking to dogmatic routine or encouraging fads.

The book does not replace others on this subject. Some mothers will prefer to use more formal sources; others will be delighted with the light, popular style of this author. The baby's father is not forgotten, but he could be given a more important place in these entertaining conversations.

HATTIE HEMSCHMEYER, R.N.
New York, New York

PENNY MARSH FINDS ADVENTURE IN PUBLIC HEALTH NURSING

By Dorothy Deming, R.N. 236 pp. Dodd, Mead and Company, New York, 1940. \$2.

In Miss Deming's latest book of the Penny Marsh series, Penny finds romance in her own life and adventure in her work. While her young doctor husband is far away in Brazil studying the *aedes aegypti* for a year, Penny learns about public health nursing in a rural

area. All of her experiences are not high adventure, however. Interwoven with exciting episodes are some of the very real problems which confront a nurse in a rural situation. Penny meets her problems with good judgment and carries on her work according to the very best practices in public health nursing.

Written primarily for the high school girl considering public health nursing as a career, the book is also interesting to the nurse experienced in rural work. The familiar situations are all there and the nurse will have a real feeling of kinship when she reads that Penny routinely carries a bag of sand and a shovel in her car.

This book with the two other Penny books should be of valuable assistance to advisers and counselors for girls.

REBA EDWARDS, R.N.
Bloomington, Indiana

GOOD HEALTH AND BAD MEDICINE

By Harold Aaron, M.D. 328 pp. Robert M. McBride and Company, New York, 1940. \$3.

Most books find their way straight from this reviewer to the library so that other people may use them. This book, I may as well confess, has stayed on my desk ever since it was received. People sometimes write to me for advice on this or that complaint, or concerning the virtues of some advertised remedy, and I have found it convenient to answer

"Look at chapter n in *Good Health and Bad Medicine* by Dr. Harold Aaron."

There are, it may be, some health problems and some remedies not mentioned in these pages but a great many are, and the advice given is reliable.

J. ROSSLYN EARP
Albany, New York

TWENTY-EIGHTH REPORT OF THE HENRY PHIPPS INSTITUTE FOR THE STUDY, TREATMENT, AND PREVENTION OF TUBERCULOSIS—1938-1939

Published by The Henry Phipps Institute, Philadelphia, 1940. Approximately 450 pp.

This volume, introduced by the director's brief report on the organization and administration of the Institute, impresses one again with the quality and extent of scientific exploration going forward at The Henry Phipps Institute in Philadelphia.

Of particular interest to nurses is the admirably planned instruction provided for students of the Department of Nursing Education and the Graduate School of Medicine of the University of Pennsylvania, and for Negro student nurses. Through an arrangement with the Department of Nursing Education a four-months' unit of instruction at the Institute, which allows each student six university credits, has been made possible. In addition to this, twenty-one special students, including physicians, public health workers, laboratory technicians, and six public health nurses from the U. S. Indian Service spent periods of study and observation at the Institute.

The research work at the Institute embraces clinical and epidemiological studies, investigation of tuberculosis among American Indians, a study of constitutional factors in resistance to tuberculosis, and a continuation of Dr. Seibert's work with Purified Protein Derivative. Investigations in the pathology of tuberculosis as well as studies in the immunology of leprosy and research of unusual interest on the question of airborne infection and the effect of ultra-

violet light on the tubercle bacillus in the air have also been carried on.

Besides the director's account, the book contains a report of the hanging of a portrait of Mr. Henry Phipps, the founder of the Institute, on the walls of the library, January 20, 1939. The greater part of the book is devoted to a collection of publications and reports by a distinguished list of contributors, covering the results of the many studies which are being carried forward.

KENDALL EMERSON, M.D.
New York, New York

PUBLIC HEALTH ADMINISTRATION IN NORTH CAROLINA

By William A. McIntosh and John F. Kendrick.
190 pp. North Carolina State Board of Health, Raleigh, 1940. Limited number free.

This description and analysis of the state health services of North Carolina by two representatives of the International Health Division of the Rockefeller Foundation will serve as example and text for many a student of that art of public service which strives to qualify as a science of civil government.

There is more text and less analysis of the structure of law in this volume than is found in those classical predecessors of this type of report by Fox and Young and their colleagues of the U. S. Public Health Service.

There is much detail of history, and generous elaboration of the multifarious functions of their development.

Critical evaluation of results and comparison with the performance of other states is less emphasized than are the methodologies and formalities of procedure.

This little book should be invaluable to the present and succeeding officers of North Carolina who will find the recommendations are amply supported by comment. Thoroughness of description rather than novelty of point of view characterizes the report.

The format, type, and arrangement of text are fairly typical of public printing

at state taxpayers' expense, and there is little to be said in their favor. These details the earnest student will not object to but it is to be regretted that the careful work of such authors should be presented in so crowded and ill-arranged a collection of 190 pages.

HAVEN EMERSON, M.D.
New York, New York

HOW TO PLAN A PUBLIC RELATIONS PROGRAM

By Mary Swain Routzahn. 20 pp. Social Work Publicity Council, 130 East 22 Street, New York, December 1939. 50c.

This bulletin is an excellent guide for outlining the publicity program for the year. Visiting nurse associations realize how important it is to inform the community about their work but frequently do not plan their public relations program. Here is help for the publicity committee.

TRENDS IN NURSING HISTORY

By Elizabeth Marion Jamieson and Mary Sewall. 570 pp. W. B. Saunders Company, Philadelphia, 1940. \$3.

This book should prove to be a welcome contribution to our professional literature because of its new approach to a basic subject. It is particularly helpful in its rational explanation of related historical data. The many cross currents which nursing encountered are here given logical sequence, and the objective explained in the introduction is particularly well achieved in the recounting of the relationship between nursing and other social and economic developments during the past nineteen centuries.

The discussion of contemporary events in both the United States and England during the early colonial, Revolutionary, and Civil War days is a departure from traditional treatment in nursing histories. By thus following the thread of historical events one feels as much aware of the contemporary scene as in the reading of a daily newspaper.

Some sections are particularly well done; others seem disappointingly meager. The discussion of Arabian medicine and the part it plays as a connecting link between the knowledge of the Eastern Empire and the later developments in the West is more clearly presented than in most texts of nursing history. But the treatment of Miss Nightingale, her epoch-making work, and the results of that work is far too sparing. Recent contributions of nursing to international relationships, and the provisions for the health program under the Social Security Act in the United States are included.

The style of the book is very readable. Well planned topics for discussion and a bibliography are appended to each chapter. If the book were to be used as a text, however, it would need to be supplemented with extensive references in order to give the student a complete account of nursing history.

DOROTHY ROGERS, R.N.
Chicago, Illinois

EXPECTANT PARENTS

Educational Programs for Expectant Parents. Analysis of Replies to a Questionnaire Survey. By Mrs. Ellen D. Nicely and Mrs. Ella Geib Greene. 73 pp. Cleveland Child Health Association, 1001 Huron Road, Cleveland, 1939. 50c.

This report of 49 replies to questionnaires sent to 48 states, the District of Columbia, and the Territory of Hawaii, gives an interesting picture of the various types of educational programs for expectant parents carried on under state and local auspices. A comprehensive list of references adds greatly to the usefulness of the material.

Manual for the Conduct of Classes for Expectant Parents. By Mrs. Ellen D. Nicely and her assistants. 137 pp. Cleveland Child Health Association, 1001 Huron Road, Cleveland, Ohio, 1939. \$1.

This manual was prepared by the Cleveland Child Health Association in answer to the many inquiries it receives about its antepartum classes. It includes lesson outlines for both mothers' and fathers' classes, with bibliographies; sug-

gestions regarding the organization of the classes; samples of the record forms and invitations used by the Association; and a review of its program. P.P.

A SYMPOSIUM ON ADOLESCENCE

Studies on Growth and Development of Adolescents and Their Implications for the Health Program of the Adolescent, by William Walter Greulich, Ph.D.

Changing Body and Changing Self, by Caroline B. Zachry.

The Adolescent in a Changing World—A Summary, by Lawrence K. Frank.

Presented at Joint Session of the Public Health Nursing and Child Hygiene Sections of the American Public Health Association and the American School Health Association at Pittsburgh. *The Journal of School Health*, May 1940, p. 133.

The public health nurse working in the schools will want to understand the organic stress and strain suffered by adolescents so that she can give really sympathetic guidance which will help the individual boy and girl to achieve maturity. While this symposium gives no outline of a health program for high schools, it includes a wealth of suggestions and references for study.

Comment calling attention to the studies made by Dr. Walter Greulich was published in the September 1940 issue, page 578, of this magazine.

In the *Changing Body and Changing Self*, Caroline B. Zachry shows how changes in growth influence the adolescent's concept of the self that he hopes and fears he will become.

In *The Adolescent in a Changing World*, Lawrence K. Frank points out the "need for a broader perspective and for some clearer conceptions of adolescence."

All three papers increase our understanding of the kind of contributions which medicine and public health might make to the protection of youth. The forward-looking nurse may use these papers to help her high school faculty attain a broader concept of the school health program and of her contribution to the individual adjustment of the adolescent.

HAROLD H. MITCHELL, M.D.
Astoria, New York

MAN AGAINST MICROBE

By Joseph W. Bigger, M.D. 304 pp. The Macmillan Company, New York, 1939. \$2.50.

While few public health nurses will find any new facts in this book, still the story it tells is always a fascinating one especially when written in Dr. Bigger's style. It is well to be reminded of the various modes of microbe transmission; the dependence upon immunity for protection against virulent invaders; the danger of "winged messengers of death" and other seemingly innocent carriers of disease.

Ever interesting are the stories of such scientists as Leeuwenhoek, Koch, Jenner, Metchnikoff, and all the many others whom the author makes live again here. Especially is this true when their photographs accompany the text.

"The most successful way," the author points out, "of controlling a [communicable] disease is to prevent the occurrence of the first case." Health control methods through food, immunology, cleanliness—especially of even slight wounds, and protection against animals and insects, are a few of the subjects discussed. A glossary and comprehensive index add to its value as a ready reference work.

BEULAH FRANCE, R.N.
New York, New York

BOARD MEMBER AND SOCIAL WORKER

The board member has his inning in a special issue of the *Survey Monthly* for November 1940, "Board Member and Social Worker." The layman's viewpoint on social work and his place in the whole welfare program of his community are the subject of a series of thought-provoking articles by laymen and professionals. Board members and executives will enjoy rating themselves and their boards respectively with the quiz on page 328. "The Meeting Will Please Come to Order," by Gertrude Springer and Kathryn Close, will have a familiar ring.

OUR LITERATURE ON SUPERVISION

Our literature on supervision in public health nursing has been meagre and for the most part borrowed from other fields. The past year brought a contribution of major importance to this field in Violet H. Hodgson's book, *Supervision in Public Health Nursing*, (The Commonwealth Fund, New York, 1939); and also the reprinting of 10 articles from PUBLIC HEALTH NURSING magazine into pamphlet form for ready use. Mrs. Hodgson's book presents in comprehensive and readable form the philosophy and methods of supervision that have evolved in our field, based upon her own rich professional experience. The reprinted articles in the N.O.P.H.N.'s little pamphlet show the emergence of our present thinking on the subject and its development over the past 17 years. (See Oct. issue, p. 645.)

Many implications of supervision are also found in the book, *The Public*

Health Nurse and Her Patient, by Ruth Gilbert (The Commonwealth Fund, 1940), which is one of the most important books which has yet appeared in the public health nursing field. Miss Gilbert's book also contains a special section on the subject of supervision.

The review of the literature in the field by a committee which selected the articles reproduced in the pamphlet showed the need for further material on subjects such as nursing supervision in official agencies, the use of consultants in statewide areas, administrative relationships as they affect supervision, evaluation of program and evaluation of the nurse's work, and the preparation of the supervisor. It is hoped that this year's beginning in the publication of material on supervision will serve as a stimulus which will be followed by further additions to the literature on this important subject.

RECENT PUBLICATIONS AND CURRENT PERIODICALS

SCHOOL HEALTH

HEALTH—A MANUAL FOR PARENTS. 22 pp. Joint Health Council, Belmont, Massachusetts, 1939. Free.

A manual of information for parents of school children in Belmont, Massachusetts, prepared by the school committee and board of health.

HEALTH SECTION REPORT, WORLD FEDERATION OF EDUCATION ASSOCIATIONS. Health Section Secretariat, 200 Fifth Avenue, New York, 1940. 60 cents.

Twenty-three papers prepared by leaders who reviewed school health activities in 13 countries of Europe, Asia, South America, and the United States for the 1939 Conference of the Health Section of the World Federation of Education Associations. These proceedings are particularly significant in that the meetings were held on shipboard off the coast of Brazil, with one session at Puerto Rico, in connection with a Goodwill Cruise to four countries of South America and eight islands of the Caribbean.

PUBLICATIONS OF THE NATIONAL LEAGUE OF NURSING EDUCATION

1790 Broadway, New York, N. Y.

ADMINISTRATIVE COST ANALYSIS FOR NURSING SERVICE AND NURSING EDUCATION. 202 pp. 1940. \$2.

The findings of this book include an accounting method, procedures for accumulating and determining various kinds of nursing data, analyses of the costs in three institutions where the method was tested, and studies dealing with the value of student service in terms of graduate service.

CUMULATIVE INDEX FOR ANNUAL REPORTS. 1940. 75 cents.

An index to the Annual Reports of the League from the first report in 1894 through 1939. The valuable material in these reports will now be more accessible for reference.

SELECTED READINGS AND REFERENCES FOR THE TEACHER OF SOCIOLOGY FOR NURSES. Marjorie Morse Crunden. 44 pp. 1940. 75 cents.

NEWS NOTES

• At the annual meeting of the Iowa State Association of Registered Nurses in October, a state organization for public health nursing was formed and the following officers elected: Adah L. Hershey, Des Moines, president; Rev. J. S. Deedrick, Waterloo, vice-president; and Alyce Rooney, Centerville, secretary.

• A Subcommittee on Nursing has been appointed by the Health and Medical Committee of the Council of National Defense, with the following members: Julia C. Stimson, Sister Olivia, Nellie X. Hawkinson, and Marion G. Howell. Miss Stimson is also chairman of the Nursing Council on National Defense. (See September issue, page 579.)

• Three committees have been appointed by the Nursing Council on National Defense: the Committee to Study Public Health Nursing Problems as They Relate to the Work of the Council; the Committee on Educational Policies and Resources; the Committee on Public Information. Ida F. Butler is serving as temporary secretary of the Council with the headquarters at the American Nurses' Association, 1790 Broadway, New York City.

NEW APPOINTMENTS

(For N.P.S. appointments see below)

Margaret Arnstein, Consultant Public Health Nurse, New York State Department of Health, New York, N. Y. (Reappointment.)
Vera Klingman, Director of Public Health Nursing, State Board of Health, Salt Lake City, Utah.

NURSE PLACEMENT SERVICE



announces the following placements and assisted placements from among appointments made in various fields of public health nursing. As is our custom, consent to publish these has been secured in each case from both nurse and employer.

PLACEMENTS

*Margaret S. Taylor, Assistant Professor of Public Health Nursing and Administrator of the Public Health Nursing Program, University of Buffalo, and Educational Director, Buffalo Visiting Nursing Association, Buffalo, N. Y.

Mary G. Devine, Senior Nurse and Director, Kenosha Visiting Nurse Association, Kenosha, Wisc.

*Genevieve Artz, Counsellor Reserve, W. K. Kellogg Foundation, Battle Creek, Mich.

Mrs. Mabel Corbett, Community Nurse, Hancock County Chapter Red Cross, Ellsworth, Maine

*The N.O.P.H.N. files show that this nurse is a 1940 member.

*Winifred V. Cushing, Staff Nurse, Waterbury Visiting Nurse Association, Waterbury, Conn.

*Mrs. Anna Dittmer, County Nurse, Hill County, State Board of Health, Havre, Mont.

*Mercedes Duncan, School Nurse, Peru Public Schools, Peru, Ind.

Mary Farrell, Staff Nurse, Visiting Nurse Association, Beloit, Wisc.

*Lola M. Hanson, County Staff Nurse, Spokane County Health Department, Spokane, Wash.

Margaret Moffat, Staff Nurse, Kern County Department of Public Health, Bakersfield, Calif.

Velma Parker, School Nurse, Powell Public Schools, Powell, Wyo.

Josephine Willy, County Nurse, Monroe County, State Department of Health, Des Moines, Iowa

Elvina Wolfe, County Nurse, Clarke County, State Department of Health, Des Moines, Iowa

ASSISTED PLACEMENT

*Helen Reinbach, County Nurse, State Department of Health, Helena, Mont.

Our Readers Say . . .

THIS COLUMN is intended to serve as a forum for the expression of reader opinion. Only signed letters will be published, although the signature will not be used except with the writer's permission. The National Organization for Public Health Nursing is not responsible for opinions expressed on this page.

SUBSCRIPTION FOR LATIN AMERICA

I am interested in your Pan-American plan for PUBLIC HEALTH NURSING, but I do not know anyone in South America. Would PUBLIC HEALTH NURSING have any names of nurses in South America doing public health work, that they could suggest as recipients for the magazine?

MARY F. THOMAS, R.N.
Wilmington, Del.

Miss Thomas was the first nurse to respond to the special subscription offer for Latin America (see October issue, page 10). We shall be glad to furnish names of Latin American nurses to receive gift subscriptions. [Ed.]

HOW DO YOU LIST HOURLY SERVICE?

How do visiting nurse associations with an hourly appointment service list this service in the telephone directory? Have any of them tried listing it in the telephone directory and the classified telephone list as "Hourly Nursing Service" or "Nurses—Hourly, by appointment?"

It is my impression that most organizations merely list the name of the organization, or perhaps list themselves under "Visiting Nursing" or "Nursing." Might it not be a good promotion idea to list the service also as mentioned above?

A Reader

DO YOU WRITE VERSES?

I am making a collection of poems about nurses, doctors, patients, and the medical work in general, for a nationwide anthology. I'd appreciate receiving either original or published poems, together with permission to publish them in book form. If a poem has been published, please specify publication, publisher's name and address, and the name of copyright holder. A self-addressed, stamped envelope should be enclosed for return of unaccepted material.

NICHOLAS LLOYD INGRAHAM
360 E. Garfield Boulevard
Chicago, Illinois

FROM SOUTH DAKOTA SCHOOL NURSE

I'd like to take this opportunity to express my appreciation for the PUBLIC HEALTH NURSING magazine. I refer to it often, and I am sure I would be lost without it.

ADELINE H. KLEIN, R.N.
Health Supervisor
Aberdeen Public Schools
Aberdeen, S. Dak.

FROM AN IOWA RED CROSS NURSE

How could we do without our PUBLIC HEALTH NURSING magazine? I wish to send along a word of appreciation for this "tool," for it is surely one continuous inspiration. It was indeed a pleasure to see in the July number pictures of the N.O.P.H.N. leaders, and to catch glimpses of the recent biennial convention sessions.

EMMA M. NORTON, R.N.
Red Cross Visiting Nurse
Boone, Iowa

"IT ISN'T SPORT"

EDITOR'S NOTE: These excerpts from a recent letter to the N.O.P.H.N. seemed to present an unusually thoughtful viewpoint on a serious question—the susceptibility of human beings to an intangible glamor connected with war. The writer catches herself falling into the habit! After asking for help with fall publicity, she adds:

Probably you are under-staffed with vacations and everything, but if you can give us a little ammunition before our battle starts in September, that would be fine; we don't need a really exhaustive report at the present stage of things.

Why do you suppose people always insert warlike items in their letters these days, as above? I notice that the children, of whom we have dozens in this neighborhood, are not playing soldier, or war, or even "Bang, you're dead." Somehow the attitude that it isn't sport has filtered down to them.

DAPHNE F. OVERBECK
Waltham, Mass.

CANNED FOODS IN THE MODERN PATTERN OF NUTRITION

● Generalities as to human nutritive requirements are of but limited use in the practical application of our modern knowledge of nutrition. This is particularly true where expert and experienced advice on diet formulation is not readily or conveniently available. For those concerned with actual diet planning or administration, more specific information on nutrition is desirable.

During recent years, several excellent texts have become available which present reliable guidance in diet planning (1, 2, 3). One important factor governing conformance with any diet pattern, of course, is the economic status of the individual, family, or group. A recent text presents a workable system in which rather full consideration has been given to this factor (1).

Under this pattern, the common foods have been classed according to their nutritive contributions into some 12 groups. These groups include milk; potatoes and sweet potatoes; mature dry legumes and nuts; tomatoes and citrus fruits; leafy green and yellow vegetables; other vegetables and fruits; eggs; lean meat, poultry, and fish; flour and cereals; butter; other fats; and sugar. There will, of course, be quantitative differences in the nutritive values of individual foods within a single group. However, there is sufficient similarity so that the foods within a group can be used interchangeably as conditioned by factors such as availability, relative costs, and personal, racial, or religious preferences. In order to minimize variation of nutritive values obtained from each food group, it has been suggested that as wide a variety of foods within a group, as practical, be consumed.

In connection with this diet plan, desirable yearly food allotments for persons of various sex, age, or conditions of life are

also listed in terms of these twelve food groups. Thus, from information regarding the sex, age, and activities of the members of a family or group, one can compute the yearly amounts of the various foods which should be provided. From the sum of these yearly totals, the food allowances per week or month for the family or group can be estimated. The latitude in the choice of foods, within the twelve specified food groups, makes the diet pattern more adaptable to situations where the economic factor must be considered.

Estimation of food requirements in this manner provides a practical method of diet planning designed to supply the nutritive requirements of an individual, a family, a group, or even a nation. However, the ultimate achievement of an improved nutritional status is dependent upon a readily available supply (at all times) of the various common foods at reasonable cost. It is apparent from the listing of the twelve food groups that many materials of a perishable nature—which are not conducive to year-round production near the centers of large populations—are indispensable in supplying the dietary requirements of our people. Thus, the transportation and storage of foods, in such a manner as to retain nutritive values, are important problems to be considered.

Needless to state, commercially canned foods are well adapted for use in this diet plan. Commercial canneries are located near the sites of abundant supply of freshly harvested foods. The canning processes convert the perishable foods into nutritious canned foods which can be economically transported and marketed throughout the year. Hence, the canning industry plays an important role in the practical aspects of diet planning to improve the nutritional status of the American people.

AMERICAN CAN COMPANY

230 Park Avenue, New York, N. Y.

REFERENCES

1. 1939. Food and Life; Yearbook of Agriculture, U. S. Dept. of Agriculture, U. S. Govt. Printing Office, Washington, D. C.
2. 1939. Accepted Foods and Their Nutritional Significance, Council on Foods of the American Medical Association, Chicago.
3. 1940. J. A. M. A. 114, 548.

We want to make this series valuable to you, so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned-foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles. This is the sixty-sixth in a series which summarizes, for your convenience, the conclusions about canned foods reached by authorities in nutritional research.



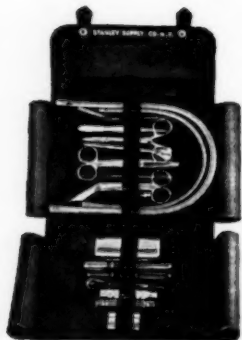
The Seal of Acceptance denotes that the statements in this advertisement are acceptable to the Council on Foods of the American Medical Association.

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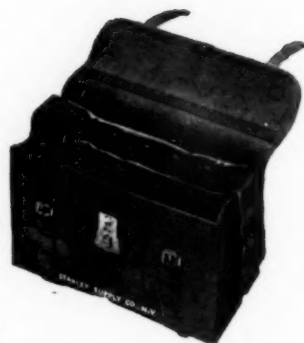
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Under this heading we will run advertisements—without display—at the rate of \$2 per each insertion of 50 words or less. Cash must accompany order to insure insertion, and copy must be received by the first of the month preceding.

The N.O.P.H.N. assumes no responsibility for nurses or positions secured through this column.

REPRINTS

Of the articles which appeared in the November issue, the following is reprinted:

Gordon—Public Health Practice in Scarlet Fever..... 20 cents

A single copy of every reprint is available to every N.O.P.H.N. member free of charge. Reprints should be ordered from the National Organization for Public Health Nursing, 1790 Broadway, New York, N. Y. On orders of less than \$1, money should accompany the order. A complete publications list, revised May 1940, may be secured from the above address.

INDEX TO ADVERTISERS

December 1940

The advertisers listed below offer their services to public health nurses in keeping them informed of all new products in this field. They are cordial in their seeking of inquiries for literature and samples. Mention PUBLIC HEALTH NURSING when you write!

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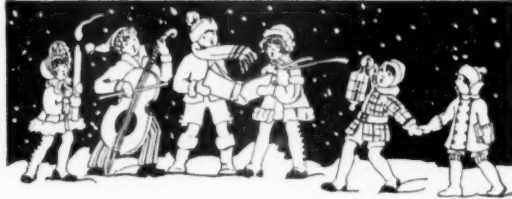
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S-13



Be of Good Cheer

GREETINGS and good wishes to every member and friend of the National Organization for Public Health Nursing!

During 1940 the N.O.P.H.N. has kept pace with the times. Advancement has come through national leadership. Now it looks ahead to another year with even greater opportunities for service as the field of its usefulness broadens.

During these days of change and uncertainty, let us all join together again to work continuously toward the ideal of better health for all!

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National Organization for Public Health Nursing

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The chemical and biological tests¹ show availability of iron in Brer Rabbit Molasses to be over 90% in the Gold Label grade and in the Green Label grade over 80%.

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TABLE¹

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MOLASSES "B"*	6.0	85	5.1
BEEF LIVER	8.2	70	5.7
OATMEAL	4.8	96	4.6
APRICOTS (dry)	4.1	98	4.0
EGGS	3.1	100	3.1
WHEAT	5.0	47	2.4
RAISINS (Muscat)	3.0	62	1.9
PARSLEY	3.2	50	1.6
BEEF MUSCLE	3.0	50	1.5
OYSTERS	5.8	22	1.3
CABBAGE	1.8	72	1.3
MUTTON	5.1	24	1.2
LETTUCE	1.5	63	0.9
SPINACH	2.6	20	0.5

*Brer Rabbit—Gold Label **Brer Rabbit—Green Label

1. Am. J. Dig. Dis. Vol. VI, No. 7 (Sept.) pp. 459-62, 1939.

2. Clinical research completed. Paper being prepared for publication.
Reprints of these papers will be sent physicians and nurses on request.



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After a thorough investigation of the evidence for and against at the close of the last period of acceptance, the Council on Pharmacy and Chemistry of the American Medical Association has again reaccepted (1935)

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